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**The Cost of the National Health Service: Problem Definition
and Policy Response 1942-1960.**

**Thesis submitted to the University of London for the degree of
Doctor of Philosophy**

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Abstract

The thesis examines how public expenditure on the National Health Service (NHS) was constituted as a political 'problem' resulting in expenditure constraint throughout the 1950s. It argues that the 'problem' related to the influence of estimates made during wartime planning which were frequently used to judge *current* expenditure from the beginning of the Service to 1960. Such estimates understated the costs of a future NHS and gave an exaggerated view of the extent to which expenditure was 'out of control'. This approach to evaluating Service expenditure was challenged by 'social accounting' reflected in the Guillebaud Report (1956). Social accounting situated NHS expenditure in the context of National Income and demonstrated that NHS expenditure increases were modest in real terms. However, such findings were resisted, particularly within the Treasury, and forms of financial control inherited from the inter-war period, continued to be used in the 1950s. The thesis explores two responses to this 'problem'. Firstly, capital expenditure is examined as a case of expenditure control. It is demonstrated that, while increased investment in hospitals was seen as promoting operational efficiency, the Treasury concern with restraining current expenditure created resistance to a larger capital programme in the 1950s. Secondly, 'managerial' techniques to promote efficiency are examined by looking at attempts to change accounting practice in the Service during the 1950s. It is argued that this experiment was constrained by criticisms of the appropriateness of applying such techniques in health; and because of their implications for medical autonomy. The overall conclusion of the thesis is that there was a disjuncture between the radical shift in health policy which led to the creation of the NHS and the perpetuation of conservative approaches to financial control.

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List of Abbreviations

AAPC	Anglo-American Productivity Council
AB	Available Beds
BDA	British Dental Association
BG	Board of Governors
BMA	British Medical Association
BPP	British Parliamentary Papers
CMB	Central Medical Board
DD	Discharged and Died
EHS	Emergency Hospital Service
GDP	Gross Domestic Product
GFCF	Gross Fixed Capital Formation
GNP	Gross National Product
GP	General Practitioner
HMC	Hospital Management Committee
IPC	Investment Programmes Committee
LCC	London County Council
LEA	Local Education Authority
MD	Mental Deficiency
MOH	Medical Officer of Health
NFA	New Fixed Assets
NHI	National Health Insurance
NHPT	Nuffield Provincial Hospitals Trust
NHS	National Health Service
NI	National Insurance
NOTB	National Ophthalmic Treatment Board
NPM	New Public Management
PESC	Public Expenditure Survey Committee
PRO	Public Record Office
RFC	Rate Fund Contribution
RHB	Regional Hospital Board
RP	Retirement Pension
TB	Tuberculosis
UK	United Kingdom
WPP	William Piercy Papers

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Introduction: the Politics of National Health Service Expenditure 1942-1960: Overview.

The objective of this Introduction is to give an outline account of the key issues related to National Health Service (NHS) expenditure over the period covered by the thesis, 1942-1960. Two major arguments are advanced. The first is that there was a persistent view amongst senior politicians and in the Treasury, over the period between the first fiscal year of the Service and 1960, that the level of NHS expenditure constituted a political problem. This was, therefore, not a short run phenomenon of the first two fiscal years, when expenditure substantially exceeded estimates, but continued to the end of the period. The second and related argument is that there was also consistent pressure to restrain NHS expenditure after the first two fiscal years. The Chronology given below outlines the major developments related to the costs of the NHS in the period covered by the thesis.

Chronology: The Politics of National Health Service Expenditure

1942	(November) Publication of the Beveridge Report, <i>Social Insurance and Allied Services</i>
1944	(February) Publication of the White Paper <i>A National Health Service</i>
1946	(March) Financial Memorandum to the National Health Service Bill
1948	(February) Estimate for the first fiscal year (1948-9) laid before Parliament
1948	(July) NHS 'Appointed Day'
1949	(September) Devaluation of the Pound
1949	(December) NHS Amendment Act
1950	(April) First meeting: Committee on the NHS
1951	(April) Resignations of Bevan, Wilson and Freeman
1951	(May) Dental and Ophthalmic charges introduced
1952	(May) Prescription charges introduced
1953	(April) Appointment of the Guillebaud Committee
1956	(January) Publication of the Guillebaud Report
1957	(September) NHS Contributions Act comes into operation
1958	(January) Resignations of Thorneycroft, Powell and Birch

Cost Estimates and the Planning of the NHS

The starting point for the period covered in the thesis is 1942. The first official estimate of the expected cost of a future NHS was included in the Beveridge Report published in November of that year (Cmd. 6404: para. 268). To understand why this estimate appeared in the Report it is necessary to explore its dual character. It was a very detailed set of proposals for the reform of social security in the narrow sense of an income maintenance system. For example, Part II of the Report, covering the 'principal changes proposed and their reasons' involved a discussion of twenty three changes to the social security system and it accounted for roughly one third of the whole body of the Report (excluding appendices) (Cmd. 6404: paras 41-192).

However, as Harris (1977: 384) has pointed out, apart from Beveridge himself, all the Committee members were civil servants and, given their involvement in wartime administrative duties, this meant that Beveridge was in a crucial position to shape the content of the final report. He adopted what she terms '...a very ambitious interpretation' (ibid.: 386) of the Committee remit. This was exemplified in a document, drafted by Beveridge, in July 1941 where social insurance was seen as 'a contribution to a better new world after the war' (cited in ibid.: 387). An indication of the scope of the Report is that Beveridge argued that 'no satisfactory scheme of social security' could be devised unless three 'assumptions' were met (Cmd. 6404: para. 301). These were 'children's allowances' (Assumption A); 'comprehensive health and rehabilitation services for prevention and cure of disease' (Assumption B); and 'maintenance of employment' (Assumption C) (ibid.).

As the ‘assumptions’ were integral to the overall ‘plan for social security’ and, as the latter had to be costed, then an estimate of what was in effect a national health service (since such services were envisaged by Beveridge as being ‘available to all members of the community’, *ibid.*: para. 301) had to be made. The need for a costing was reinforced because, while Beveridge aimed to sweep away the pre-war health insurance system, he wanted a contribution to the future funding of the health service from insurance contributions (*ibid.*: paras. 430 and 437). This meant that a costing was required to determine the level of insurance contributions which would be needed in the post-war period.

The estimate was prepared by the Ministry of Health in consultation with the Government Actuary, Sir George Epps (Honigsbaum, 1989: 197-8). It was for Great Britain and put the likely gross cost at £170 million (see Appendix 1 for a discussion of the financial control terms used in the thesis) , roughly one sixth of the total cost was for the service in Scotland (*ibid.*: 198). This figure was published in the Beveridge Report (Cmd. 6404: para. 268).

The Beveridge Report did not include any detailed account regarding the structure of a future NHS. Thus, referring to the kind of service envisaged under ‘Assumption B’, Beveridge indicated that ‘most of the problems of organisation of such a service fall outside the scope of this Report’ (Cmd. 6404: para. 428). Such issues were, however, addressed, in an initial form, in the 1944 White Paper *A National Health Service* (Cmd. 6502) and a further estimate of the expected cost of the Service was included as Appendix E. This gave a gross cost figure of £147.8 million for Great Britain; £132 million for England and Wales; £15.8 million for Scotland (*ibid.*: 84-5).

The final key estimate of the planning stage of the NHS was that included in the Financial Memorandum to the NHS Bill. The gross estimate for England and Wales was £152 million (Financial Memorandum to the NHS Bill, 1946:iii) and for Scotland was £22 million (ibid.). It is important to note that this estimate (published in March 1946 , Honigsbaum, 1989: 198) followed a major policy shift with respect to the structure of the Service outlined in the 1944 White Paper. In the latter hospital services were to be provided by municipal hospitals funded partly out of rates and partly out of grant from central government; and voluntary hospitals funded by voluntary contributions and also by central government grant. However, after the 1945 election, Bevan adopted a policy of hospital 'nationalisation' bringing both municipal and voluntary hospitals under, ultimate, central government control (for a discussion of the rationale for this policy see Honigsbaum 1989: ch. 16; Webster 1988a: 84-6). This meant that central government had the de facto responsibility for *financing* the Hospital Service. Thus Webster (1998: 23) shows that, whereas central government sources were envisaged as accounting for 63.6 per cent of total expenditure in the 1944 White Paper the corresponding figure in the Financial Memorandum was 95.8 per cent (calculated from ibid.). The corollary has been that political bargaining at *central* government level has been crucial in the history of the NHS and Webster (1998: 30) has argued that '...the standard achieved within the health service depended on the success of the Minister of Health's advocacy during each round of the public expenditure negotiations'.

The next major expenditure estimate was that for the first (part-year) of the Service. The 'appointed day' for the start of the Service was 5th July 1948 thus it was to operate for roughly nine months in its first fiscal year. The England and Wales estimate for this part-

year, laid before Parliament in February 1948, was £175.5 million (Webster, 1988a: 134). If this is annualised then it gave an estimate for England and Wales of £234 million some 61 per cent higher than the Financial Memorandum figure. This increase was substantially in excess of inflation rates in this period. No specific index of health service costs is available but Feinstein (1976: T 133) gives indices for both 'consumer goods and services' and 'public authority goods and services'; these moved in a similar way over the 1946-8 period with prices increases for the former of 13.8 per cent and for the latter 13.5 per cent (calculated from *ibid.*).

The First NHS Financial Crisis

However, notwithstanding this large increase in the estimate a major 'crisis of expenditure' (Webster 1988a: 133) was triggered by the disjuncture, in the first two fiscal years of the Service, between estimates and expenditure out-turns. In 1948-9 gross expenditure for Great Britain exceeded the estimate by 39 per cent (calculated from *ibid.*: 135). The 1949/50 Great Britain estimate was 33 per cent higher than the (annualised) expenditure figure for 1948/9 (calculated from *ibid.*). Nevertheless gross expenditure in that fiscal year was still 27.5 per cent higher than the estimate (calculated from *ibid.*). Thus the gross expenditure out-turn in 1949-50 was nearly 70 per cent higher than the (annualised) estimate for 1948-9.

The political significance of these expenditure over-runs must be set in the context of the economic problems which confronted the Labour Government. Concentration of production, during wartime, on the war effort had meant that exports had fallen to 30 per cent of the pre-war level (Cairncross, 1985: 6). This fall and the corresponding balance of payments problem was sustainable due to American assistance via lend lease

but its withdrawal, in August 1945 (Morgan, 1984: 145), meant that exports had to be boosted.

The trade problem was exacerbated by the liquidation of foreign assets held by UK nationals (Cairncross, 1985: 7, see also Barnett, 1986: 38); and shipping losses of 28 per cent of total tonnage (Cairncross, 1985: 7). Such problems were more difficult to deal with because of sharp deterioration in the terms of trade relative to the end of the inter-war period (*ibid.* 10 and 43). With respect to the latter Feinstein's index shows an increase in British export prices, 1938-47 of 122 per cent as against an increase in import prices of 158 per cent over the same period (calculated from Feinstein, 1976). In addition to the need to expand exports in a context of unfavourable terms of trade there were crises related to problems of coal supply in 1947; and the devaluation of the pound in September 1949.

The Chancellor, Cripps, did not respond to the 1949 devaluation with a strictly deflationary policy. However, the NHS expenditure over-runs were seen as problematic in the context of a need to control public expenditure in the immediate post devaluation period (*ibid.*: 175). Pressures for greater control over, *inter alia*, social services expenditure also stemmed from changes in the machinery of government. The Central Economic Planning Staff was established in the spring of 1947 with the remit of preparing, in collaboration with the Economic Section of the Cabinet Secretariat, an economic survey designed to make more effective use of scarce resources (Land et al. 1992: 10). An Economic Policy Committee was created whose remit included seeking to reconcile '...conflicts between the needs of our foreign trading and the requirements of our internal economy', this was chaired by the Prime Minister and first met in October

1947 (ibid. 214). Tighter controls were also exerted on capital investment via the Investment Programmes Committee a committee of civil servants which reviewed investment programmes and first met in January 1948 (ibid. 216). Land et al have seen such developments as putting social welfare programmes like health under 'stricter economic scrutiny' (ibid.: 10).

The combined impact of the precarious economic position which confronted Labour; the pressures exerted by the fuel and devaluation crises; and more rigorous economic controls can be seen in the political fall-out from the expenditure over-runs of the first two fiscal years. Anticipating problems from the over-run of the first fiscal year, Bevan and Woodburn (the Secretary of State for Scotland) issued a 'progress report' in December 1948 which both included a revised *part-year* estimate, in the case of England and Wales for £225 million and an account of why the over-run had occurred (Land et al. 1992: 129; Webster, 1988a: 134). In January 1949, the Lord President of the Council, Morrison, wrote to Attlee requesting an inquiry into the operation of the NHS (Webster 1988a: 134 and 422), a request for greater Cabinet scrutiny which was not taken up at this point in time.

The expenditure over-runs which had been identified resulted in supplementary health estimates for 1948-9 (ibid.: 137). Cripps's concerns over NHS expenditure were reflected in, inter alia, proposals for dental, ophthalmic and prescription charges and the abolition of the Supplementary Ophthalmic service (ibid.: 139). From the beginning of the Service charges had been levied for amenity beds (National Health Service Act, 1946: Section 4) and for beds for private patients (ibid.: Section 5 (1)). However, the proposed charges

could be seen as more significant politically since they created a potential financial obstacle to patients seeking core NHS care.

Expenditure trends for 1949/50 indicated, as early as July 1949 (Webster, 1988a: 143), that a further supplementary estimate would be needed. Cripps also maintained pressure for expenditure control in the context of his attempts to cut domestic consumption following the devaluation of September 1949 (Land et al., 1992: 130). This included a renewed case for charges and Webster (1988a: 144 and 422) points to no opposition from Bevan to a prescription charge when the Economic Policy Committee debated proposals for economies in October 1949. However, his response has to be set in the context of the other main part of his portfolio at the Ministry of Health, housing. Thus both Webster (1988a: 143) and Land et al (1992: 130) point to Bevan's concessions on prescription charges as linked to an attempt to resist cuts in housing expenditure (for a discussion of the October 1949 housing cuts see Land et al, 1992: 78-9). The power to levy prescription charges was embodied in the NHS Amendment Act 1949 (Section 16) and the amendment, originally introduced at the Lords committee stage, was carried in the Commons in December 1949 (Webster, 1988a: 146-7 and 424).

However, the interpretation of Bevan's acquiescence on prescription charges as tactical is confirmed by his campaign to frustrate the use of the powers conferred by the 1949 Act. Thus Foot (1975: 290) points to Bevan's remark in the December 1949 Commons debate on the NHS Amendment Act that he was not 'displeased' that the administrative difficulties of imposing charges were registered in the debate. Thus, for example, critics of charges raised issues regarding their implications for those in need of continuous treatment, and hence continuous medication (see for example Hansard, 9th December

1949, Col. 2237 (Byers) and *ibid.* 2243 (Jeger). Bevan perhaps signalled his lack of enthusiasm for charges by concluding that the debate had shown the problems ‘of carrying out principles which many people have so glibly proposed’ (*ibid.*: Col. 2259).

A key element in Bevan’s approach related to a structural difficulty in applying charges. In order to head off problems generated by the financial obstacle to service use which they pose exemptions are given to those deemed in need of such support but they both reduce yields and increase the administrative costs of collection (see for example, Klein, 1995: 35). In the case of the proposed Labour charges concessions to the war-disabled and old-age pensioners cut the expected yield. This was further reduced by Bevan, reverting to what Webster (1988a: 146) calls his ‘natural mood’, deciding to impose a charge on a per script rather than a per item basis (*ibid.*). Such anticipated reductions in the revenue from charges enabled Bevan to suggest to Cripps that ‘...we must review amongst ourselves whether these exemptions make the game worth the candle’ (cited in *ibid.*: 147).

Thus Bevan was able to use the virtual inevitability of exemptions as a means of frustrating the introduction of prescription charges (Campbell, 1987: 183). However, the anticipated supplementary estimates for 1949-50 were published in March 1950 (Webster, 1988a: 150) and, in an attempt to defuse criticisms that public spending was out of control, Cripps effectively promised an expenditure ceiling for 1950/51 (*ibid.*: 151; Land et al. 1992: 131; Lindsey, 1962: 104). The issue of charges was re-opened and, following an intervention by Harold Wilson, the President of the Board of Trade, charges were deferred but a Cabinet Committee was formed to monitor NHS expenditure (Webster 1988a: 154). This implemented the Cabinet scrutiny which Morrison had

sought in the first fiscal year of the Service. The Committee was chaired by Attlee and had its first meeting in April 1950 (Land et al., 1992: 217). It worked by considering monthly statements of expenditure and 'remedies' were to be applied if costs seemed likely to exceed the limits set for the fiscal year (ibid.).

Following the substantial cost over-runs of the first two fiscal years expenditure in 1950-1 was consistently in line with the estimates (Webster, 1988a: 161 and 163).

However, pressures on the NHS were triggered, in the lead up to the 1951 Budget, by a planned increase of over 50 per cent in defence expenditure for 1951/2 (ibid.: 168). The Chancellor, Gaitskell, pressed for the imposition of charges for dentures and spectacles (ibid.: 174) and commanded Attlee's support. Bevan (then Minister of Labour), Harold Wilson and John Freeman (Under-Secretary at the Ministry of Supply) resigned in April 1951 and the charges came into operation in May 1951 (Lindsey, 1962: 106; for details of the charges see National Health Service Act 1951).

The Politics of NHS Expenditure under the Conservatives 1951-1960

The Conservatives returned to power October 1951 and the implementation of prescription charges and a flat rate charge for dental treatment were announced in January 1952 (Webster, 1988a: 192; for details see National Health Service Act 1952).

However, the charges imposed were much more limited than those initially favoured by the Minister of Health, Crookshank, who, for example, had supported a hospital boarding charge (Bridgen and Lowe, 1998: 44); and the Treasury which had proposed increasing the number of pay beds (ibid.). The Treasury also wanted to challenge the principle of a comprehensive service by abolishing the Supplementary Ophthalmic and Dental services for 'non-priority' groups (ibid.).

This disjuncture between a more radical 'economy' programme and a substantially more modest package of charges with no major changes in coverage of the Service resulted from a more cautious approach in the Cabinet (*ibid.*: 45) and some Conservative backbench resistance (*ibid.*). The continued resistance to either charges or major reductions in the scope of the Service led to a change of approach in the Treasury. From the first cost over-runs the Treasury had been concerned over levels of NHS expenditure but the negative reaction to more radical economy proposals led to pressure for an independent inquiry which, it was hoped and anticipated, would serve to smooth the way to the acceptance of a more substantial programme of economies. The subject of the independent inquiry was raised at the Cabinet in February 1953 (Bridgen and Lowe, 1998: 46) and there was considerable debate regarding the appropriate remit for the committee. The division was between economic liberals, particularly the President of the Board of Trade, Thorneycroft, who sought an explicit reference in the remit to find means of reducing NHS expenditure; and other Ministers, such as the Minister of Health, Macleod, who saw such an approach as in danger of representing the Conservatives as anti-welfare state (*ibid.*: 46, Webster, 1988a: 204). The Chancellor, Butler, persuaded Thorneycroft to accept a more 'neutral' remit (Webster, 1988a: 204). In line with this remit the Committee was chaired by the Cambridge economist, Claude Guillebaud, who has been regarded as a non-partisan figure (Webster, 1988a: 205; Glennerster, 1995: 87; for Labour concerns that the Committee was designed to cut NHS expenditure see Hansard, 1 April 1953 Col. 1230 (Bevan) and *ibid.*, 30th April 1953, Col. 2243, W. Griffiths).

The Guillebaud Committee reported in January 1956 and its conclusions were antipathetic to an economic liberal agenda. It stated that it could not recommend any means to 'reduce in a substantial degree the annual cost of the Service' (Cmd. 9663: para 721). Equally it did not recommend any significant increase in the scope of charges indicating that it could not suggest any 'new sources of income' (ibid.). In addition it argued, with respect to hospital capital expenditure, that 'we have found it necessary, in the interests of the future efficiency of the Service, to make recommendations which tend to increase the future cost' (ibid.).

These conclusions were crucially influenced by research undertaken for the Committee by Brian Abel-Smith and Richard Titmuss. This research, on NHS expenditure trends in England and Wales, from the beginning of the Service to 1953-4, was effectively sub-contracted to Abel-Smith and Titmuss by the Committee (Webster, 1988a: 206-7; Bridgen and Lowe, 1998: 49;). Their influence particularly related to the estimate that the current net cost of the Service (see Appendix 1) had fallen from 3.75 per cent of Gross National Product in 1949/50 to 3.24 per cent in 1953/4 (Webster, 1988a: 208). Abel-Smith and Titmuss's findings on capital expenditure were even more dramatic suggesting that, in real terms, capital spending in 1952/3 was running at roughly one third of the level at the end of the inter-war period (ibid.: 209); and this was the basis for the Committee's recommendation for an enhanced capital programme (ibid.). The Committee's Report can be seen as a vindication of the Service and the limited expenditure commitment to the NHS revealed in its Report could be seen as linked to its conclusion that fundamental structural changes in the structure of the NHS and major increases in charges were not required (Allsop, 1984: 75; Shepherd, 1994: 95).

Guillebaud had revealed a pattern of parsimony with respect to the funding of the Service. However, the publication of the Report did not lead to a significant reduction in pressure to restrain NHS expenditure. This is exemplified by Bridgen and Lowe (1998: 49) who refer to developments in 1956-7 as 'Guillebaud ignored'. Continued pressure on expenditure surfaced in a variety of ways. In October 1956 prescription charges were increased to 1/- (5p) per item (Lindsey, 1962: 109; Webster, 1988a: 214). This increase followed a familiar pattern since the Treasury had pressed for a broader package of charges including a 2/- (10p) per item prescription charge, hospital boarding charges and increased charges for dentures (Lowe, 1989: 512). Equally, although Guillebaud had recommended substantial increases in NHS capital spending, , Thorneycroft, the Chancellor of the Exchequer, was still advocating a substantial reduction in such spending in January 1957 (Webster, 1996: 47).

This continued pressure stemmed both from the Treasury's commitment to the view that the NHS should be the principal source for economies in social services expenditure (Bridgen and Lowe, 1998: 49); and the pronounced economic liberal character of the Treasury political team which included Enoch Powell as the Financial Secretary to the Treasury (ibid.: 50). In one respect these trends appeared to be checked when, following the failure to effect what they regarded as sufficient reductions in public expenditure, the whole Treasury team (Thorneycroft, Powell and Birch, the Economic Secretary to the Treasury) resigned in January 1958 (ibid.: 16; Jarvis, 1998). However, while this may have hampered the implementation of a radical economic liberal programme it did not remove pressures for restraint in NHS expenditure.

In part the response to the failure to find scope for large reductions in NHS expenditure was a change of approach to NHS finance. In addition to the increased charges of 1956 the NHS Contributions Act of 1957 doubled the existing insurance contribution (ibid.: 52). This meant that the 'contribution' to the NHS from the National Insurance Fund increased from 6.4 per cent of NHS funding in 1956/7 to 14 per cent in 1959/60 (Webster, 1996: 806). This was designed to reduce the demands of the NHS on general taxation and was seen as the Ministry of Health as a means of resisting drastic expenditure cuts (Bridgen and Lowe, 1998: 50-1).

While a radical economic liberal agenda was not implemented by Conservative governments in the 1950s an examination of expenditure trends reveals the extent of parsimony with respect to expenditure in this period. An expenditure series in real terms has been constructed by Appleby (1999: 84) for NHS expenditure in the UK in constant (1985) prices. This shows an increase in expenditure in real terms of 20.2 per cent over the period from 1950-1 to 1959-60 (calculated from ibid). This is broadly in line with another series of NHS expenditure for the UK in real terms given by Webster (1996: 804) (in 1970 prices) which gives an increase of 21 per cent over the same period (calculated from ibid.). To set these figures in longer-term perspective they are comparable with those under the Thatcher governments of the 1980s. Thus Appleby's series indicates that, over the period 1979-80 to 1988-89, real NHS expenditure in the UK rose by 18 per cent (calculated from ibid.). Thus, notwithstanding the frequent characterisation of the 1950s as a 'consensual' period in social policy (an issue discussed in detail in Chapter 1) increases in NHS expenditure in real terms were similar to the avowedly 'anti-consensual' Conservative governments of the 1980s.

This overview has sought to outline the major developments in the politics of NHS expenditure in the period under review and has pointed to the persistence of both a concern with levels of expenditure on the Service and pressures for economy. Chapter 1 examines how these issues have been discussed in the academic literature and formulates the research questions which will be addressed in the thesis.

Chapter One: The Politics of NHS Expenditure 1942-60: Literature Review, Research Questions and Methodology

The object of this Chapter is to consider the way in which the issues discussed in the Introduction have been analysed in the key academic literature, to examine the research questions thrown up by this literature and to provide a rationale for the methodological approach adopted in the thesis. The Chapter is divided into five sections: the first considers how the academic literature has evaluated the ‘problem’ of NHS expenditure in the period under consideration. It concludes that most commentators, influenced by Abel-Smith and Titmuss’s research, have tended to see the ‘problem’ as exaggerated. An important exception is the work of Correlli Barnett as he sees both the welfare state and the NHS as a significant burden on British economic performance in this period. The second section of this Chapter gives a critical review of his arguments in the light of the principal academic literature, concluding that there are fundamental flaws in Barnett’s argument. His arguments do not undermine the case that the NHS expenditure ‘problem’ was based on misconceptions. The third section considers the politics of NHS expenditure in the light of arguments that the period was characterised by a consensus in social policy and in health policy. It concludes that arguments for ‘consensus’ in these areas have been subject to significant criticisms in the academic literature and that the constraints on NHS expenditure are consistent with the argument that economic liberal views played a major role in policy making in social policy and health policy in this period. The fourth section examines issues related to the politics of NHS expenditure, in the period under review, which emerge from the academic literature and which need to be researched. It outlines the research questions which will be pursued in the thesis. The fifth section discusses and gives a rationale for the research methodology used.

Evaluating the ‘Problem’ of NHS Expenditure

As has been demonstrated in the Introduction, NHS expenditure was constituted as a political problem in the period under review. It is the object of this section to discuss how this ‘problem’ has been analysed in the academic literature. This literature includes histories of the NHS (e.g. Lindsay, 1962, Webster 1988a and 1996, Klein, 1995); biographies of major politicians (e.g. Foot, 1975, Williams, 1979); and accounts of the political and economic context of policy making (e.g. Morgan, 1984; Cairncross, 1985). The histories of the NHS vary in that some (e.g. Lindsay, 1962) were written at a time when access to unpublished official documents was not possible; while others (e.g. Klein, 1995) cover very broad periods and make limited use of such documents. In contrast Webster’s official history of the Service (1988a and 1996) is based on primary historical research. Biographies provide detail on particular key events (e.g. the 1951 resignations) and give contrasting pictures of major protagonists (as in the case of Foot, 1975 on Bevan and Williams, 1979 on Gaitskell). Works on the political and economic context of policy making are valuable in locating policy in the broader framework of health in relation to other social services (e.g. Morgan, 1984); or to the economic pressures on social service expenditure (e.g. Cairncross, 1985). Broadly the literature reviewed concludes that it was unjustified to treat NHS expenditure as a major problem.

The most discussed single set of events has probably been the resignations of Bevan, Wilson and Freeman. However, as Webster (1988a: 161-3) has pointed out, one of the ironies of these resignations was that reports to the NHS Committee during fiscal year 1950-1 showed expenditure trends in line with estimates and no supplementary vote was required for the NHS in that fiscal year. As was indicated in the Introduction, the pressure

on health expenditure stemmed from the roughly 50 per cent planned increase in defence expenditure which has, generally, been seen as over-ambitious (Eatwell, 1979: 144; Smith, 1993: 182).

Both Bevan and Wilson (on Wilson, see Pimlott, 1993: 160) stressed that the issue of charges for dentures and spectacles had to be seen in the context of the broader question of the respective claims of health and defence on public expenditure. The grounds for the 1951 resignations are important because they are part of a broader questioning, in the literature, of the economic rationality for pressures to constrain health expenditure. This includes arguments that cutting health expenditure in 1951 was pointless because the projected size of the defence programmes was unrealistic; that anxiety over early cost over-runs was misplaced because the demand for dentures and spectacles was high but only temporary; and that, in comparative terms, the NHS was not an expensive health service.

With respect to the 1951 resignations Cairncross (1985: 228) has argued that Bevan's objections to the size of the rearmament programme, on the grounds that shortages of materials meant that it would be impossible to effectively spend the allocation, were sound (for similar arguments see Morgan, 1984: 459-60 but Williams, 1979: 281-2 gives an account which is more sympathetic to Gaitskell). This line of argument takes on added significance in the context of the small expected revenues from dental and ophthalmic charges (Pimlott, 1993: 160).

Scepticism over the economic rationale for constraints on NHS expenditure has also been reflected in views of the substantial cost over-runs of the first two fiscal years of the Service. A major contributory factor in these over-runs was the unexpectedly high

demand for dentures and spectacles. However, this has been argued to reflect a backlog of demand which was an effect of limitations on provision during the inter-war period (Lindsey, 1962: 103; Watkin, 1978: 32-3). In turn Lindsey (1962: 103) has argued that once this backlog had been dealt with these parts of the Service settled ‘...to a more normal pattern of performance’ (see also Gemmill, 1960: 71-2).

Commentators have also pointed to the relatively low cost of the NHS either as a whole or with respect to particular parts of the Service in comparative terms. Thus Lindsey (1962: 122) cites a figure for US health expenditure as accounting for 6.6 per cent of US national income in 1961 as against 3.6 per cent for the UK and 1959-60 (see Abel-Smith 1967 for broader comparative evidence which comes to similar conclusions). Equally, while the growth of cost per prescription in the UK raised policy concerns (see, for example Webster, 1996: 13), Gemmill (1960: 70) cites figures for average cost per prescription in the NHS in 1958 at under half the Canadian and less than one third of the US average.

In line with this view of the Service as relatively cheap to run there has been a tendency to see views of NHS expenditure levels as excessive as involving distorted or myopic judgements. Thus, for example, Klein (1995: 36) suggests that ‘by the beginning of the 1950s the NHS was stereotyped as a spendthrift organisation’; and Webster (1996:5) has argued, with respect to the first decade of the Service, that ‘the NHS struggled along in an atmosphere of suspicion in government quarters’ and that ‘the Treasury in particular cultivated the view that the health service was a wasteful and extravagant experiment’ (ibid.).

In particular the view that political concerns over the level of NHS expenditure was objectively unsustainable has been reflected in the status accorded to the Guillebaud Report and particularly to the research of Abel-Smith and Titmuss. This account has frequently been seen as a definitive refutation of concerns over NHS profligacy in the early history of the Service. Thus Webster (1988a: 207) argues that Abel-Smith and Titmuss's book 'furnished Guillebaud with convincing economic arguments refuting the widely held belief that the National Health Service was...escalating in cost'. In a similar vein Lindsey (1962: 119) states that Guillebaud's conclusions on cost trends were both based on 'carefully assembled data' and were 'beyond question'; and Eatwell (1979: 145) sees Guillebaud as vindicating Bevan's resistance to NHS economies.

However, while concerns with the level of NHS expenditure have generally been seen as unfounded and prejudiced there is one important exception to this pattern from an author whose work has generated a substantial critical debate in the 1980s and 90s. This alternative view comes in the work of Correlli Barnett who has argued that the cost of the British welfare state in general and the NHS, as a key part of that structure, was a major cause of the poor relative performance of the British economy since the Second World War. Clearly, if Barnett's contention is sound, then the sanguine view of NHS expenditure trends outlined in this section cannot be sustained. In the next section Barnett's arguments and the critical literature related to them are discussed.

The Burden of the Welfare State; the Burden of the NHS?

The Barnett Thesis

Barnett's arguments are principally presented in two key works *The Audit of War* (1986) and *The Lost Victory* (1995). The argument is that, while Britain emerged from the Second World War with fundamental problems of international indebtedness (Barnett,

1986: 40); and a need for substantial industrial investment (ibid.: 42). during the War the reform of social policy engendered a substantial and damaging diversion of resources into the provision of social services. The privileging of such social reform stemmed from its status as part of a broader moral reform project for British society which Barnett calls 'New Jerusalem' and which he sees as rooted in a Nineteenth Century romantic reaction to British industrialisation (ibid.: 12).

The costs of the post-war welfare state were seen, he argues, as a secondary consideration. He cites evidence on the relatively limited attention given to cost issues in the planning of the post-war welfare state. Thus, with respect to the Beveridge Committee, '...out of a total of forty four meetings of his committee and 248 memoranda the basic question of national resources for the scheme only came up in three meetings and eight memoranda' (Barnett, 1986: 45); and these figures exaggerate concerns relating to costs *internal* to the Beveridge committee since three memoranda on costs came from outside the committee (from the Government Actuary and the Economic Section) (ibid.). A similar lack of concern with welfare costs can be found in the post-war Labour government. Thus in planning social security provision in 1945 and 1946 the Social Security Committee considered 56 memoranda but only three referred to cost, all from the Government Actuary (Barnett, 1995: 134).

Barnett sees this moral imperative to create a welfare state irrespective of its costs as damaging to the British economy. However, this is not an economic liberal critique. The indictment is not of social services expenditure per se but rather the concentration on 'unproductive' forms of such expenditure. Here Barnett includes expenditure on social security, health and housing. However, an appropriate role for the state is to create the

conditions for higher economic growth by investment in technical education (Barnett, 1986: 204 and 210).

The NHS is categorised as an ‘unproductive’ social service. The creation of the NHS *and* expenditure trends in the Service are seen as problematic. NHS costs were ‘inexorably rising’ and attempts to control them were ‘tinkering resembling nothing so much as endeavouring to fit brakes on a toboggan already committed to the Cresta Run’ (Barnett, 1995: 151). This reflected Bevan’s status as a quintessential New Jerusalem social reformer imbued with moral purpose (ibid.: 137).

This account is thus radically different from the verdict on the trajectory of NHS expenditure presented in the majority of commentators reviewed in the first section. The logic of Barnett’s position is that expenditure on the welfare state in general and the NHS in particular were excessive. A considerable critical literature has been generated by the Barnett thesis. It has concentrated on three key issues: how far is the characterisation of an indifference to costs correct; how far is Barnett’s unfavourable comparison of Britain with competitors supported by comparative data; finally were critical resources diverted from British industrial investment into welfare provision?

Indifference to the Costs of a Welfare State?

Barnett’s ‘indifference to costs’ thesis has been subject to criticism both with respect to Beveridge and the 1945-51 Labour governments. This literature concludes that both Beveridge’s plans and major social welfare measures introduced by Labour were significantly modified in the light of economic constraints.

On Beveridge Harris (1990: 187) disputes Barnett’s claim that the Beveridge Committee was unconcerned with cost arguing that ‘...the vast bulk of the Beveridge committee

papers...are devoted to discussions...about methods of keeping costs down'. Equally she points to revisions to social security proposals by Beveridge in the context of discussions with Keynes (who is, for Barnett, another representative of New Jerusalem, see Barnett, 1986: 17) driven by cost considerations. Thus, in a paper on 'The Problem of Pensions', of August 1942, Beveridge argued that while full subsistence pensions should be 'the ultimate goal' they could not be justified 'in view of the vital need of conserving resources particularly in the aftermath of war' (Harris, 1977: 411).

With respect to the Labour governments Tomlinson has also pointed to modifications to social policy objectives in the light of economic considerations. Thus, for example, while Labour did raise the school leaving age from 14 to 15, in 1947, the target in the 1944 Education Act was 16 (Tomlinson, 1995: 196-7); and he also points out that this decision was 'agonised over' because of its implications for the supply of labour (ibid.: 197). Equally restrictions on educational capital spending were reflected in the admission, by the Labour Minister of Education, George Tomlinson, in March 1950, that of 2827 school buildings blacklisted in 1925, 636 were still in use (ibid.: 201).

Similar austerity has been traced in social security policy. Thus Tomlinson (1998: 69) points out that benefit levels were constrained by Labour's adherence to Beveridge's policy of flat-rate insurance contributions which were difficult to raise because, as a regressive tax, they bore heavily on low incomes. As he points out (ibid.) this funding constraint could have been offset if Exchequer contributions were sufficiently high. However, Labour adopted an Exchequer contribution *lower* than either that recommended by Beveridge or the Wartime Coalition government (ibid.). The result of such funding restraints was limitations on benefit levels and restrictions on the right to

claim benefit. Thus unemployment benefit was paid subject to a time limit (ibid.: 70) a more conservative option than that recommended by Beveridge who had proposed making unemployment benefit at full rate 'indefinite in duration' (Cmd. 6404: para. 129).

British Social Welfare Expenditure in Comparative Context

Barnett's argument involves a claim that British economic performance was compromised but that competitor nations did not replicate the errors of 'New Jerusalem'. Germany is seen as the model to which Britain should have aspired (for a discussion of conceptions of a 'German model' in Barnett see Edgerton, 1991).

If Barnett's argument is to be sustained then one corollary would appear to be that the share of national income devoted to social services expenditure ought to have been substantially higher in Britain than in key economic competitors. However, critics have argued that the comparative statistical evidence does not support Barnett's argument. Thus Harris (1990: 179) has pointed out that Barnett fails to discuss a number of key comparative sources on social service expenditure. These reveal a quite different pattern. Thus, (ibid.: 180), citing comparative work by Flora (1983), she shows that UK social security and pensions expenditure in the 1950s was not high by Western European standards and was significantly *lower* than Western Germany.

There are similar problems with Barnett's arguments on housing expenditure. Thus Tomlinson (1997: 231) shows that, whereas in Britain in 1950, 19 per cent of gross domestic investment was on dwellings, the corresponding figure in Western Germany was 24 per cent. He points out that while the *immediate* post-war Labour public housing programme was substantial radical reductions were effected in the post 1947 period (ibid.: 230). He (ibid.: 230-1) also shows that the comparative data on manufacturing

investment is, in Barnett's terms, favourable to Britain with 30 per cent of gross domestic investment in Britain in 1950 devoted to manufacturing investment as against 27 per cent in Western Germany. There are also difficulties with another aspect of Barnett's argument on comparative economic performance which traces a disdain for industry and commerce to the origins of British industrialisation (Barnett, 1986: 210). However, as Edgerton (1991: 373) points out, if German social and economic organisation was deemed to be more efficient from the Nineteenth Century it is difficult to reconcile this picture with German GDP per worker being lower than British until *after* World War II.

The Negative Economic Effects of the Welfare State on the Economy?

A central theme of Barnett's (1995) book is that construction of a post-war welfare state was damaging to British economic performance but this view had been criticised particularly by Tomlinson (1995, 1997 and 1998). Comparisons of the share of national income devoted to social services expenditure discussed above involve two distinct elements; transfer payments (notably social security) which do not involve direct consumption of resources in real terms; and provision (such as education, health and housing) which does involve such consumption (Tomlinson, 1995: 196). Equally, as Tomlinson points out, such a distinction is particularly pertinent to the economic significance of the British welfare state in the 1940s because it was created in a context of shortages of materials like steel and timber and of labour shortages (ibid.). This raises the question, how far did the creation of a welfare state pre-empt the use of scarce material resources diverting them from industrial and commercial uses?

Tomlinson (1995) has pointed to major difficulties with the argument that the welfare state made damaging demands on the British economy. With respect to education he

points out (ibid.: 197) that, while the raising of the school leaving age in 1947 did cut the workforce by 400,000, teacher recruitment was not seen as problematic because the principal labour shortages in this period were in manual occupations. Cairncross (1985: 390) points out that three key ‘undermanned’ industries caused most concern to government, agriculture, coal-mining and textiles (ibid.). On the capital investment side the demands of education were very modest, accounting for only 1.3 per cent of the value of gross fixed investment in 1948 (Tomlinson, 1995: 198); 3.5 per cent of the allocation of building workers in 1947 (ibid.:199) and 0.2 per cent of the steel allocation in 1948 (ibid.: 200).

Tomlinson has presented similar evidence with respect to the demands of the NHS in terms of labour and materials. The principal labour demands in the NHS were for nursing and domestic labour and growth in employment, particularly for domestic employees in the NHS was disproportionately part-time (ibid.: 206) Thus most of the growth in demand would have been for women workers who, with the exception of cotton spinning, would not have been seen as an alternative workforce in the industries identified as ‘undermanned’ given the ‘norms of the time’ (ibid.; 205-6). Equally health also made very limited demands on capital resources: its share of the allocation of building workers was even lower than education (ibid.: 200).

If there was a social services competitor to industrial investment then this might appear to be housing. It took 15.5 per cent of gross fixed investment by value in 1948 (ibid.: 198) and 60 per cent of building workers in June 1947 (ibid.: 199). However, there are difficulties in identifying a threat to industrial investment. The major reason was that industrial investment required steel for factories and machinery yet housing was an

insignificant user of steel (*ibid.*: 200, see also Chick, 1996: 401 for Barnett's failure to appreciate the strategic significance of steel supply).

Given the tightening of the economic controls over welfare state expenditure discussed in the Introduction, it is clear that, contrary to Barnett's arguments, industrial investment was generally privileged over welfare expenditure under Labour. As Tomlinson (1997) points out, this is obscured in Barnett's argument because of selective quotation from historical documents. Thus he criticises the Attlee government for a small projected increase in industrial investment in 1948 while ignoring an 18 per cent *cut* in housing investment indicated in the same document (*ibid.*: 238, see also *ibid.*: 236 for further examples of selective quotation in Barnett, 1995).

Barnett's critics have pointed to difficulties with sustaining a claim that the creation of the post-war welfare state crucially diverted resources from industrial and commercial applications. Commentators have also discussed under-theorisation in his argument. The underlying assumption in Barnett's thesis is that if alternative uses of labour and materials had occurred a substantially higher rate of economic growth in the British economy could have been achieved. However, this presupposes that higher industrial investment automatically translates into higher economic growth and/or that a greater supply of suitably trained labour translates into such growth. But investment-growth or supply of trained labour-growth relationships are themselves contentious. Tomlinson (1997: 229) point out that 'the proposition that investment is the key to economic growth' is treated by Barnett (1995) 'as a self evident truth'. Yet, as he argues, it has been the subject of considerable debate in the applied and theoretical economics literature (*ibid.*).

In a similar vein Edgerton (1991: 366) has argued that Barnett *assumes* rather than demonstrates a connection between technical education and economic growth.

Barnett's uneasy handling of economic mechanisms can also be seen in his discussion of the relationship between the welfare state and the economy. He (1986: 42) criticises Beveridge for failing to consider 'the cost of maintaining full employment' in terms of its impact on industrial investment. He later suggests that full employment encouraged resistance to technical change on the part of the British workforce (Barnett, 1995: 353). However, he fails to point out that post-war full employment operated to *cut* certain social security costs. Tomlinson (1998: 73) points out that the Government Actuary reported, in 1954, that unemployment and sickness benefit claims were lower than had been anticipated leading to a stronger balance in the Insurance Fund than had been envisaged in 1945/6 when the post-war social security programme was being planned. There are also problems with Barnett's tendency to treat expenditure on housing as non productive. As Tomlinson (1995: 203) points out, it was seen by the Plowden, the Head of the Central Economic Planning Staff, as a means of improving labour mobility and hence increasing industrial production. It is also not clear why Barnett sees an opposition between 'full employment' and 'industrial investment'. One of the features of the post Second World War economic boom was the central role played by private sector investment (Cairncross. 1985: 37). It has been argued that a commitment to full employment can be seen as creating a 'virtuous' economic circle where demand generates investment which, in turn, increases the capacity for further expansion' (ibid.: 38)

Thus, Barnett's critics have produced a damaging indictment of his thesis: the claimed unconditional commitment to a substantial post-war welfare state by both Beveridge and the 1945-51 Labour governments appears to be greatly exaggerated. Britain was not a 'high' welfare spender in the context of Western European competitors; and the evidence that the post-war welfare state did extensive damage to post-war recovery in the 1945-51 period is insubstantial. This suggests that Barnett's arguments should not lead to a revision of the 'majority' view that the 'problem' of NHS expenditure in the period covered by this thesis was exaggerated. However, if this argument confirms claims regarding parsimony in social services expenditure generally and in health in particular this has implications for another important body of historical and social scientific literature, that on 'consensus'. This is discussed in the next section.

Consensus on Social Policy; Consensus on the NHS?

The post-war welfare state and the NHS involved both substantial increases in population coverage and the aim of substantially improved service standards. The corollary was an expanded role for the state. This has raised the question of whether there was a 'consensus' on social policy in which the major political parties and the Treasury accepted this enhanced state role. Equally there are a number of subsidiary questions: if there was a 'consensus' when did it begin; and did it cover the whole spectrum of social and economic policy or was it limited to discrete areas? The debate on this question is relevant to the object of this thesis because, as was pointed out in the Introduction, the 1950s was a period of parsimony in NHS spending and this suggests resistance to an expanded role for the state.

Consensus on Social Policy?

As Lowe (1990: 156) points out, it is impractical to expect a situation in which there is universal agreement on all aspects of policy. Thus a 'welfare consensus' could not mean, a complete identity in social policy between the major political parties. Given that 'consensus' allows for policy difference it should not be identified with unanimity but rather what Lowe calls 'a historically unusual degree of agreement' (ibid.). This approach suggests that concepts of consensus will involve a comparison of periods some of which, putatively, exhibit such an 'unusual' degree of agreement as against others which do not (Kavanagh, 1992: 177). In this respect the period under review could be contrasted with the post 1979 period particularly because of Mrs Thatcher's explicit repudiation of what she saw as a post-war consensus (Lowe, 1990: 152; Jones, 1992: 9).

With respect to 'consensus' there are alternative periodisations. One important strand of argument sees the post-war consensus as framed during the Second World War in the coalition government which operated after May 1940. Addison's book *The Road to 1945*, originally published in 1975 and reissued in a new edition in 1994, has been a major source for this interpretation. He characterises the wartime coalition as 'the greatest reforming administration since the Liberal governments of 1905-14' (Addison, 1994: 14). This reforming administration was part of a 'new consensus which was positive and purposeful' (ibid.). The Conservative and Labour parties had by-passed their ideological differences in favour of 'pragmatic' reform (ibid.). The significance of consensus in this period was demonstrated by key pieces of wartime legislation the 1944 Education Act and the 1945 Family Allowances Act and the issuing of White Papers on Social Insurance (1943); A National Health Service (1944) and Employment Policy (1944). The

implication is that they were coherent, embodied cross-party support and Treasury endorsement.

A number of commentators have argued that this is not a satisfactory account of the wartime developments. Thus Jefferys (1987: 132) has argued that the 1943 Social Insurance White Paper was acceptable to the Conservatives because it did *not* involve a commitment to Beveridge's principle that benefits should be at subsistence level (see also Kopsch, 1970: 108-114). In contrast Labour saw the subsistence principle as fundamental and regarded the White Paper as a short-term measure which did not adequately embody an appropriate basis for social security (Jefferys, 1987: 133; but also note Addison's argument that the post-war Labour government did not *implement* subsistence level benefits, Addison, 1994: 287). This is consistent with Jones's argument that the wartime Conservative parliamentary party was predominantly economic liberal in its ideological stance (Jones, 1996: 5).

Similar arguments can be advanced on the 1944 Employment Policy White Paper. Thus Lowe has argued (1990: 167) that it was too 'contradictory and flawed' to serve as a guide to postwar policy. He points out that the first three chapters, largely informed by Treasury thinking, concentrate on microeconomic problems whereas the final three chapters, reflecting Economic Section views, were more sympathetic to Keynesian approaches, stressed macro-economic management and were more optimistic on the potential effectiveness of government intervention (*ibid.*, see also Jefferys, 1987: 137-9).

There are thus doubts on how far an argument for a wartime social policy consensus can be sustained. An alternative approach would be to see consensus as *post-war*

phenomenon. Thus Lowe (1990: 160) has argued that repudiation of the Conservatives by the electorate in 1945 engendered a fundamental policy rethink.

However, historians have pointed to a continued Conservative emphasis on market-based forms of provision. Thus Zweiniger-Bagielowska (1994: 186-7) has argued that the Conservatives sought to exploit frustrations stemming from rationing and shortages in the 1945-51 period by portraying them as an effect of socialist policies which would be obviated by a return to free enterprise. Equally Conservative policy documents of this period continued to embody a clear commitment to economic liberalism. The policy document 'The Right Road for Britain' (1949) stated that Britain was faced with a choice of two roads 'one leads downwards to the Socialist state, and inevitably on to Communism, with all individual freedom suppressed, and living standard lowered'; while the other 'the Conservative road' aims 'to free the productive energy of the nation from the trammels of overbearing state control and bureaucratic management' (cited in *ibid.*: 186). This hardly suggests a notion of softening the emphasis on inter-party differences to render the Conservatives 'electable'.

It could be argued that a more rigorous test is provided by Conservative policy *in office* after 1951. Here an apparently striking contrast with post 1979 'non consensual' policy is provided by the case of housing. As Bridgen and Lowe (1998: 204) point out 'the Conservatives built more council houses between 1951 and 1956 than any other government during a five year period'. Equally this substantial public housing commitment was fulfilled even though there were warnings from senior Conservatives of the potential economic difficulties stemming from the allocation of resources to housing (see, for example, Jones, 1992: 241 and 252). This would appear to be sharply at variance

with the post-1979 privatisation of local authority housing and thus reflects an ‘unusual’ level of inter-party agreement. However, again, commentators have shown that such contrasts can be exaggerated. Arguments that Conservative housing policy in the 1950s reflected a ‘consensual’ approach suggest that this implied a commitment to a collectivist view of housing where the state was to provide high quality housing for rent. The apparently converse approach, embodied in Conservative housing policy in the 1980s, is to see public housing as playing a residual role. However, with respect to Conservative housing policy in the 1950s, strong residualist aspects have been identified.

The public housing programme under the Conservatives involved building to significantly lower standards than had prevailed under Labour (Merrett, 1979). The public housing targets have also been seen as a political ploy, adopted by the Conservatives because Labour’s post 1948 failure to increase completions was seen as a point of political vulnerability (Bridgen and Lowe, 1998: 203). This was crucial to Churchill’s consistent support for the programme even in the light of pressures to limit housing completions on grounds of the damage to the balance of payments (Jones, 1992: 253-4; Bridgen and Lowe, 1998: 206). However, the policy also came under attack as excessively collectivist. Thus Lord Woolton complained, in a memorandum of June 1952, that reliance on council housing was inconsistent with Conservative political principles (Bridgen and Lowe, 1998: 208).

The Conservative decision to play a housing ‘numbers game’ limited the scope for an immediate shift away from an emphasis on public provision. However, the literature points to moves in a residualist direction which culminated in legislation in the mid 1950s. The Housing Subsidies Act 1956 differentiated the subsidies for general needs and

for slum clearance with the latter set at a level over double the former (Malpass. 1990: 91). Malpass (ibid.) has pointed to the Conservative Minister of Housing and Local Government, Duncan Sandys, arguing, in the debate on this legislation, that local authority housing, was to be targetted on those in need and ‘the justification for housing subsidy is need, and, in our opinion, need alone’ (cited in ibid.). He concludes (ibid.) that this demonstrated a Conservative commitment to residualist principles where public housing should be reserved for those who did not have the means to avail themselves of private alternatives.

There has also been substantial scepticism on the extent of consensus politics with respect to other areas of Conservative social and economic policy in the 1950s. In education the inter-party gap widened with Labour’s commitment to comprehensive education as official policy in 1953 (Jones, 1992: 361). In contrast a consistent feature of Conservative education policy in the 1950s was support for grammar schools and this was reflected in a refusal to sanction comprehensive reorganisation where this required replacing or absorbing an existing grammar school (Simon, 1991: 172,187 and 211). Similarly Rollings (1994) has argued that Conservative commitments to full employment in the 1950s were ambiguous. He points out that, while the Conservative Manifesto for 1950 contained a commitment to full employment, this was followed by a ‘long section’ stressing the need to cut public expenditure and taxation’ (ibid.: 195-6). This is indicative of a conditional endorsement of Keynesian policies. Similarly he shows (1996: 111) that, even when unemployment was rising in 1958, the achievement of a high level of employment was treated, by the Cabinet Economic Policy Committee, as less important than maintaining a strong currency and stable prices.

A further issue which has been debated in both the historical and political science literature is the extent to which the machinery of government adjusted to the expanded role of the state in the post-war period. Of central importance here is the Treasury, the department charged with the control of public expenditure. The forms of Treasury control inherited from the inter-war period have been seen as inconsistent with such an enhanced state role. Expenditure control focused on annual budgets but Lowe (1999: 45) has pointed to longer time scales as appropriate to the funding of social policy programmes. Research on the Treasury as late as the 1970s showed that it was insufficiently staffed to maintain an independent research capability (Heclo and Wildavsky, 1981: 42) which meant that it had neither the capacity nor the inclination to scrutinise the basis of 'spending' department estimates (*ibid.*). The same research showed a hostility to the use of statistical methods in policy analysis (*ibid.*: 45).

Such research pointing to the limitations of the Treasury in controlling and evaluating large social service programmes can also be situated in the context of a broader literature on the Administrative Grade of the Civil Service. Thus it has been argued that in the higher echelons of the Civil Service there was a downgrading of specialist knowledge in favour of an emphasis on the 'generalist' (Kellner and Crowther-Hunt, 1980: 33; Theakston, 1995: 81-2). That there was excessive movement between departments so that expertise was not developed (Kellner and Crowther-Hunt, 1980: 35; Theakston, 1995: 100). The Administrative Grade has also been seen as a closed group and weakness in specialist expertise was not offset by late entry to the Service because it was on too small a scale (Kellner and Crowther-Hunt, 1980: 42; Theakston, 1995: 100).

However, as Lowe (1989 and 1997a) has pointed out, there was an attempt to change the basis of Treasury practice in the mid 1950s but one which, ultimately, foundered on a continued emphasis on economy in public expenditure. A key figure was Richard (later Sir Richard) 'Otto' Clarke who had served as Head of the Treasury Social Service Division in the early 1950s. Immediately before the 1955 election Clarke proposed a five year survey to relate expenditure commitments to economic growth (Bridgen and Lowe, 1998: 14). This could be seen as a break with traditional Treasury practice in various ways. The time scale for budgetary purposes was extended. Quantification was required to estimate future economic growth and projected public expenditure. Decision making was extended to a review across social service programmes rather than bilateral negotiations between 'spending' departments and the Treasury.

However, as Lowe (1989) points out this proposal was not an attempt to adjust to a new era of higher public expenditure but rather a new means of advancing the traditional Treasury objective of controlling, and ideally, reducing public expenditure. Clarke's proposal was taken up in the creation of the Social Services Committee, formed in 1956 (Bridgen and Lowe, 1998: 298). However, the Treasury unsuccessfully sought to insert a target for 'savings' in the Committee's remit (Lowe, 1989: 510) and advanced a number of ill thought out economy proposals which were resisted by non-Treasury ministers on the Committee (ibid.: 512-4). Equally the commitment to economy led to specious estimates which combined pessimistic forecasts of national income with exaggerated estimates of future social service expenditure (ibid.: 515-6).

Lowe (1989) concludes that this biased approach strengthened ministerial resistance to expenditure cuts in the late 1950s. In a later work (Lowe 1997a) he has shown that a

similar pattern applied to the Public Expenditure Survey Committee (PESC) introduced in the early 1960s which sought to coordinate spending plans with projected economic growth (Bridgen and Lowe, 1998: 19). Again rather than a concern with 'value for money' in public services the Treasury emphasis, with Clarke again playing a central role, (Lowe, 1997a: 611-12) was on economy. This again engendered ministerial resistance to a biased Treasury agenda (ibid.: 611) and undercut the potential advantages which might have flowed from a longer-term and broader evaluation of social policy (ibid.: 612).

There is thus a substantial literature on the continued significance of economic liberal precepts. During the Second World War economic liberal views were dominant in the Conservative Party. In opposition 1945-51 a free market critique of socialism was salient. In office the Conservatives did not dismantle the welfare state but collectivism was adopted as an expedient and pressure for constraint on public expenditure was a consistent feature. At the level of the machinery of government there were attempts to change the basis of financial control but within an overriding framework of economy. The final part of this section examines the issue of consensus in health policy.

A Consensus on Health Policy?

The literature on health policy consensus can be distinguished from that on social and economic policy because of the different roles ascribed to political parties. The literature on social policy in general focuses on how far the policies and practices of the major political parties converged. However, as Webster (1990a) points out, an important strand in the literature on consensus in health policy stresses the *marginal* role played by

politicians particularly in the creation of the NHS. This, in turn, reflects a view of health policy which sees it as driven by technical rather than political determinants.

A key source in this respect is Eckstein (1958) who stressed the importance of organisational deficiencies in pre-NHS provision such as the lack of integration between municipal and voluntary hospitals as at the root of the project to reform health care in Britain (see for example *ibid.*:109-114). This posing of the health problem as one of inadequate organisation is largely because he argued that there were no major political divisions on health policy (*ibid.*: 109). Equally, for Eckstein, the driving force behind the creation of the NHS was the medical profession (Webster, 1990a: 118) and this is particularly reflected in the activities of key pressure groups such as the British Medical Association (BMA) (*ibid.*: 119), with the role of political parties and the state seen as relatively insignificant (*ibid.*: 120).

This approach stressing the minor role of politicians is continued by Klein in the first edition of his book, *The Politics of the National Health Service* (1983). His account, however, is distinguished by an extension of the groups seen as driving health reforms including not just the medical profession but also the upper echelons of the civil service. Thus he (1983:2) argues that, by 1939 a consensus had emerged which was ‘dictated...by the logic of circumstances rather than by the ideology of politicians’. The reference to the ‘logic of circumstances’ is linked with a stress on the perceived organisational weaknesses of pre-NHS provision as central to the consensus. Thus Klein claims that the project of creating an NHS was crucially shaped by ‘rationalist paternalists both medical and administrative’ and that the ‘voice’ of this consensus was of those ‘not so much outraged by social injustice’ as ‘intolerant of muddle’ (*ibid.*: 5).

A broader thesis has been advanced by Fox. In his view conceptions of the appropriate medical division of labour and the increased efficacy of medical interventions involved a combination of dissemination of knowledge down a medical hierarchy (from teaching hospitals at the apex) and reference of patients up the hierarchy (to specialists) (Fox, 1986a: 208; Fox, 1986b: 34). Organisationally such hierarchies are organised in 'regions', areas large enough to sustain the standards of medical service appropriate in a modern health care service (Fox, 1986a: 19). This is seen as an *international* phenomenon and the NHS is merely an instance of this trend to 'hierarchical regionalism' (Fox, 1986b: 33). Consequently the logic of Fox's position is that *national* party politics is of relatively marginal significance and he argues that a similar service to the NHS would have come into operation if either the Conservative or Liberal parties had won the 1945 election (ibid.: 50; for discussion of the links between Fox, Eckstein and Klein see Webster, 1990a: 118-121).

By the mid 1980s the idea that there was a consensus on health policy which led to the creation of the NHS had become an orthodoxy. However, this approach has been criticised by Webster (1988b and 1990a) and this critique has built on the first volume of his official history of the Service (Webster, 1988a). The nature of this criticism can be illustrated by examining the debates around hospital organisation following the 1944 White Paper *A National Health Service*. In one sense the structure proposed in the White Paper might seem to fit with the technical rationality approach to policy formation suggested in Eckstein, Klein and Fox. It proposed, at a local level, that hospital authorities would be 'joint authorities' i.e. joint boards of county and county borough councils (Pater, 1981: 79). In part this structure embodied a technical rationale since, as Pater (ibid.) points out, most individual local authorities were 'too small to provide all normal hospital services'. However, the role of

hospital authorities was politically contested. While voluntary hospital interests sought to assert their independence from local authority control the local authorities saw their leading role as rooted in their status as elected bodies. Thus as Webster (1990a: 128) points out, there was not one (technocratic) version of 'regionalism' but rather a local authority and a voluntary hospital variant whose content and underlying assumptions differed radically.

The White Paper approach was designed to align the size of the hospital authority with the range of services to be supplied under the NHS but the basis of political conflict concerned the relationship between the voluntary hospitals and the joint authority. Under the proposed structure voluntary hospitals were not obliged to enter a future NHS but if they did not do so then they would not obtain access to state funding. However participation was subject to conditions which restricted voluntary hospital autonomy. These included observing national standards of pay and conditions for staff; and that voluntary hospitals be open to inspection and audit (Pater, 1981: 79-80). Equally such hospitals would operate within the context of the plan drawn up by the hospital authority, a feature which would limit the hospital management's ability to determine the range of specific clinical services provided.

These restrictions on their autonomy were not seen as acceptable by the voluntary hospital lobby and Webster (1988a: 62) argues that 'the White Paper was seen as a threat to their status and independence'. The voluntary hospital strategy consisted in seeking the creation of an alternative structure which precluded voluntary hospital subordination to local authorities while maintaining access to funding from the state. Thus, as Webster (*ibid.*) points out, the voluntary hospital campaign against the White Paper included the proposed setting up of a Central Hospitals Board covering general policy and administration; a Regional Hospital Council with overall responsibility for planning and consultant services

and a Local Hospital Council designed to supersede the Joint Authorities in hospital policy at a local level. At all these levels voluntary hospitals were to have *parity of representation* with local authorities.

This conflict was also reflected in inter-party divisions. Thus, within the Coalition Government, the Conservative Minister of Health, Henry Willink, made a number of concessions to voluntary hospital interests in the negotiations following the publication of the 1944 White Paper. For example, local health service councils, while they would retain an elected majority would also contain a 'sizeable' medical representation (Webster, 1988a: 69). These concessions, in which local authority influence was significantly reduced, reflected a Conservative view of the role of the voluntary hospital. Thus, Willink, in his unpublished autobiography, argued that the wartime Conservative Party would not have accepted the emasculation of the voluntary hospitals (Jefferys, 1987: 135; see also Kopsch, 1970: 178). In contrast Attlee, while he accepted the 1944 White Paper as a compromise arrangement, saw no long term role for the voluntary hospitals in a future National Health Service (Webster, 1988b: 195; see also Brooke, 1992: 205-6 and Taylor, 1977: 93 for other Labour reservations on proposals in the 1944 White Paper).

However, if there are difficulties in the claim that there was a consensus on health policy during the Second World War which smoothed the way for the creation of the NHS this does not preclude the possibility that such a consensus was a *post-war* phenomenon (Kavanagh, 1992: 185). As was indicated earlier, the argument for a post-war consensus rests, particularly, on Conservative responses to the electoral defeat of 1945. While difficulties with such arguments in other areas of social policy have been outlined above

there are aspects of Conservative health policy in the 1950s which might appear to sustain the view that such a consensus operated.

These include the argument that, while pressures to restrict its scope operated, such as frequent proposals to abolish the 'non-priority' Dental and Ophthalmic services, the broad range of Service coverage did not change during the 1950s (Bridgen and Lowe, 1998: 41; Webster, 1994: 55). Equally while both the scope of charges and the revenue yield from them increased during the 1950s, most services remained free at the point of use (Bridgen and Lowe, 1998: 41.). In addition while the Conservatives had introduced prescription charges they were implementing legislation passed by Labour (*ibid.*). There is also the relatively 'neutral' remit of the Guillebaud Committee (Watkin, 1978: 34) which, arguably, created the space for it to investigate cost trends rather than operate as part of an economy drive.

However, if the emphasis is shifted to expenditure trends and patterns of funding then a rather different picture emerges. As was pointed out in the Introduction, the 1950s was a period of NHS expenditure constraint. Equally there were important changes in funding. It is the case that the Service remained predominantly tax financed but there was an important shift, after 1957, to increasing reliance on insurance funding. Seen in distributional terms this involved a move to a *de facto* regressive form of taxation in order to restrict recourse to the more progressive option, general taxation. Thus, for example, Webster (1994: 57) points out that, over the period 1949/50 to 1958/9 the Exchequer contribution to the Service rose by only £50 million, from £345 to £395 million. Thus it can be cogently argued that, in health policy, as in other areas of social and economic policy, there was a distinctive Conservative agenda. Equally this was strongly imbued with economic liberalism and, as

Bridgen and Lowe (1998: 41) argue, with respect to the 1950s ‘within both the Conservative Party and the Civil Service the concept of a free and comprehensive NHS remained a matter of intense controversy’. Thus the academic literature on health policy shows similarities to the broader literature on social and economic policy. Inter-party differences had an important influence on policy making and there was not a clear inter-party agreement on an enhanced role for the state.

The Central Research Questions Addressed in the Thesis

The argument so far has sought to outline how the historical and social science literature has treated the ‘problem’ of NHS expenditure in the period under review. In this section it is necessary to examine the key questions thrown up by this literature which will constitute the principal research issues addressed in the thesis.

The Question of Benchmarks

The first problem stems from an apparent paradox. On one hand the restraints on expenditure, the imposition of a wider range of charges and the political conflicts over the level of NHS expenditure are indicative of a persistent view of NHS expenditure levels as problematic. On the other hand, the majority of commentators who have discussed this issue, following Abel-Smith and Titmuss (1956), have concluded that such concerns were exaggerated and misplaced. This, then, raises the question, if such concerns were objectively unfounded, why did they persist?

This is not an issue which has been systematically investigated but one important line of research has been suggested in the literature. If NHS expenditure was perceived as a political problem then there must have been a standard or benchmark which constituted it as one. Webster argues that the NHS struggled in an atmosphere of ‘suspicion’ in government

circles during the first decade of the Service (Webster, 1996: 9). In attempting to account for this 'suspicion' he states that one of the 'main objective foundations' were 'the unrealistically low speculative estimates for the cost of the service made before its inception' (ibid.). He does not give documentary support for this argument but there are two references in other parts of the literature supporting his position. Laybourn (1995: 232) cites a memorandum, sent to Morrison, by one of his advisers, in March 1950 which directly contrasted the level of NHS expenditure at that time with that given in the 1946 Financial Memorandum to the NHS Bill and this comparison was used to justify a sharp reduction in expenditure on the Service. Similarly, Bridgen and Lowe (1998: 43) argue, with respect to the Treasury in the 1950s, that there was 'a continual harking back to the initial estimated costs'.

This supports Webster's view that early estimates, made in the planning stage of the NHS, served as key benchmarks. Equally these estimates were characterised by Webster (1996:9) as 'unrealistically low'. This suggests a need to examine whether and, if so, how and why such early estimates served as benchmarks.

Reasons for the Inaccuracy of the Estimates

It also raises the question as to why the estimates were 'too low'. The first possibility is that there was deliberate manipulation with under-estimates designed to allay possible objections to the creation of the Service on the grounds of its cost. However, as Tomlinson (1995: 211) points out, although Bevan was suspected of such manipulation by some of his Cabinet colleagues, this accusation was rebutted by the Cabinet Secretary, Norman Brook in a note to Attlee of March 1950 (ibid.).

There are two other broad approaches to accounting for the under-estimate. One relates to the argument that there was an absence of data which could have served as the basis for forecasting the cost of what was a radically different Service in terms of scope, coverage and standards to that which had prevailed in the inter-war period. Thus Foot (1975: 250) attributes to Bevan, and supports the view that no 'worthwhile estimate' of Service cost could be given until the Service came into operation. Lindsey (1962: 99) claims that 'when the program was in the development stage it was not possible to determine accurately its cost'.

However, there is also an alternative view which suggests deficiencies in the *use* of data. This is, perhaps, implied in Webster's reference (1996:5) to 'speculative' estimates. Equally both Klein (1995: 32) and Campbell (1987: 180) have seen the estimates as, respectively 'extrapolating pre-war health care expenditure'; and that 'the amounts...spent on health care before the war' were 'projected forward'. Thus these authors suggest deficiencies in the approach to cost estimation within the Ministry'. Webster (1988a: 133) has also pointed to a contemporary critique by Robb-Smith (1944) of the estimates in the 1944 White Paper. These considerations raise the need to research how far inaccurate estimates reflected inadequate data and how far inadequate use of data. Equally it is also worth asking whether these different reasons for under-estimation themselves varied in importance between different parts of the Service.

Variations in the Expenditure Control Problem?

This reference to the distinct elements of the Service raises a further important question. That is whether expenditure control problems varied between the different parts of the Service. For example, Webster (1988a: 137-8) points to very uneven increases in cost

estimates between fiscal years 1948/9 (annualised) and 1949/50 between, at one extreme, a quadrupling of costs in the Ophthalmic service in England and Wales to an 8 per cent rise in the General Medical Service. Of course, the Service was diverse in its forms of remuneration encompassing fee for service payment (e.g. dental care), salary (e.g. nurses and consultants) and capitation (general practice). Thus an important research issue is whether and, if so, why cost control problems varied by the part of the Service concerned and if cost control problems in given areas change over time (such as, for example, the 'backlog' issues discussed in the Introduction).

The Politics of NHS Expenditure under Labour and the Conservatives

As was pointed out in the Introduction, Bevan's decision to 'nationalise' hospitals, the most expensive part of the Service, meant that NHS expenditure was predominantly determined at the level of central government. Webster (1988a: Ch. iv) has shown how the 'crisis of expenditure' under Labour related to important political divisions between the Left of the Party, particularly represented by Bevan and the Right, particularly represented by Gaitskell and Morrison. This, in turn, raises the issue of how this conflict was played out in terms of evidence on NHS expenditure deployed by both sides in this conflict.

As was argued above, the work of Abel-Smith and Titmuss has exerted a major influence over subsequent commentary on trends in NHS expenditure in the period under review. This work was significant not just because of its findings but also because of the methodological approach adopted. The 'social accounting' approach (Hagenbuch, 1958) laid emphasis on trends in Service expenditure in real terms (adjusted for inflation) and as a share of national income. This was an alternative way of constructing a benchmark for NHS expenditure. However, Bridgen and Lowe's (1998: 43) reference (see above) to 'harking back' to original

estimates suggests that this methodological shift did not dispel the 'problem' of NHS expenditure. It is necessary to ask why this was the case in the 1950s and why both Conservative politicians and the Treasury appear to have continued to support early estimates as benchmarks.

The discussion of consensus generally operates with the presumption that there is a unity to approaches to social policy. In one sense this is reasonable, since, if state intervention is seen as either desirable or undesirable, this might be expected to be reflected *across* different services. However, Webster (1996: 801) has shown that a *particularly* parsimonious regime appeared to apply to health in the 1950s so that, for example, the share of health in overall public expenditure on social services fell from 24.6 per cent in 1950/51 to 21.2 per cent in 1959/60, as against, for example, education which increased its share from 18.1 per cent to 23.7 per cent over the same period. This raises the question of the 'poor relation' status of health in the 1950s and the question of the underlying politics of such relative treatment of health expenditure as against other social services under the Conservatives.

The Effects of Parsimony

This regime of parsimony necessarily had a wide range of effects. These ranged from the perpetuation of regional variations in GP list sizes (Webster, 1996: 12); in the availability of dentists (*ibid.*: 16) and of consultants (*ibid.*: 23). Given the range of potential effects of expenditure restrictions it is not possible, within the scope of this thesis, to address all these issues but two, in particular are focused on. These are the pattern of capital expenditure on the Service in the period; and the use of management techniques within the NHS in the 1950s.

As was pointed out in the Introduction, the most dramatic area of expenditure restraint was on capital expenditure involving a substantial cut in real terms when contrasted with estimates of pre-war capital spending. This suggests a line of investigation into why such restraints were so marked and what their effects were at the level of, in particular, individual Regional Hospital Boards (RHBs), Board of Governors (BGs) and Hospital Management Committees (HMCs).

Finally, one of the points of continuity in the period was the fact that the range of services offered, in broad terms, remained unaltered. At the same time a tight regime of expenditure control was applied. This combination of a Service whose structure remained broadly constant and a priority for expenditure control raises the issue of how far there was a search for 'efficiency' gains in the Service. In turn this suggests the examination of whether attention was given to changes in methods of Service management. In this thesis the particular manifestation focused on is the attempt to introduce management accounting techniques into the NHS in the 1950s. Thus Webster (1988a: 297) has pointed to, *inter alia*, two reports from the King's Fund and the Nuffield Provincial Hospitals Trust which were commissioned by the Ministry of Health in 1952. Both sought to effect important changes in the form of presentation of NHS accounts so that they could be used more effectively as a means of management control. This suggests a need to investigate the significance and impact of the early form of 'managerialism' in the NHS.

Methodology

The thesis is a work of contemporary history and the range of methods deployed in this field are rich and varied (for surveys see Seldon, 1988 and Brivati et al, 1996). In addition to the substantial secondary literature the thesis makes use of contemporary literature, diaries (e.g

Williams, 1983) and party publications (e.g. the collection in Craig, 1975). However, the principal method of investigation used in the study is historical archive research, in particular, the use of the modern departmental records lodged at the Public Record Office (PRO) at Kew. This section is designed both to give a rationale for this approach, a discussion of the limitations of such documentary research and how these limitations might be offset.

The use of original documents at the PRO is related to two major objects of the thesis: to explore how cost estimates were prepared; and to analyse the thinking of politicians and officials on the costs of the Service and its implications for policy. To explore these issues it is necessary to go beyond the secondary literature discussed above and published government sources such as White Papers and the reports of Select Committees.

With respect to cost estimates neither the Beveridge Report nor the 1944 White Paper contain substantial information on how the estimates were arrived at. The departmental estimates for the first part-year and the first full year key were illuminated by testimony by officials before the Select Committee on Estimates (1949). However, while this source is important it naturally this reflects the public face of the Ministry and should be supplemented by examination of departmental records.

Original sources are also valuable for indicating how policy agendas are set and equally how certain positions and evidence are excluded. The volume of work in modern state departments necessarily means that there is substantial devolution of decision-making to officials at the lower levels of the policy machine (Roper, 1977: 276-7). PRO sources allow an examination of the 'filtering' role of officials which, in turn, relate to the political stance of individual civil servants or a departmental 'view' (Lowe, 1997b: 249). Furthermore issues

of the impact of policy at a local level can also be examined because the PRO contains records of, for example, individual Regional Hospital Boards (in the MH 88 file) which have the potential for case study material on the impact of (limited) capital investment on individual hospitals and these will be discussed in Chapter Seven..

Limitations of Documentary Research

While, however, use of original documents allow a greater richness of analysis their limitations must also be recognised. These can be broadly classified in the following way: there may be important discussions which escape the official documentary record (Land et al., 1992: x); there are records which contain an account of discussions and decisions but in a summary form (ibid.); there are partial or distorted accounts of discussions (ibid.: xi); finally there are limitations on access due to preservation policy or official restrictions on access. Many of these limitations are related to the fact that the records used in a thesis of this kind are those of working departments of state and are not designed for the purposes of historians.

Non-recording can occur because key discussions take place at informal meetings or via telephone discussions and these are not minuted (Land et al., 1992: x). This reflects the working practices of the department but there are also cases in which there are deliberate decisions not to minute a formal meeting, in some instances these reflect relations of distrust between officials and ministers (ibid.).

Restricted accounts occur where a record is kept but in a limited form such that, for example, only the decisions or a broad summary of the discussion is recorded. Such records will thus fail to indicate, for example, which ministers took which positions in a debate. Such restrictions have particularly been seen as applying to records at the apex of

government decision-making (e.g. Cabinet and Cabinet Committees) (Roper, 1977: 262). This, in turn, reflects changes in practices of minuting at this level which derive from the 1920s, before this it was common to give extended summaries of each Minister's views (see Land et al., 1992: x). There is also the issue of accounts which give a distorted view of a discussion. Thus Lowe (1997b) gives an example of the marked contrast between a verbatim record of a Conservative Cabinet meeting in 1962 with the official minute of the meeting. In this case, of course, there was a check on the accuracy of the official minute but this is not the norm.

A final problem is the question of whether the researcher has access to sources and whether they have been destroyed. One disadvantage in the period under review is that only a small part of it is covered by the 1958 Public Records Act. This extended PRO supervision of the preservation of documents (earlier legislation left much more discretion to the departments) (see Roper, 1977 for details). On the other hand with the general closed period of 30 years applying to documents those which do survive will be (mainly) available to the researcher.

While there are these important limitations there are, of course, various means of trying to cope with them. Diaries, memoirs and private papers provide an alternative source both to check and fill in gaps. For example Gaitskell's diary records that a meeting was not minuted because Cripps, then Chancellor, had sent out officials because he wished to complain about the politically slanted advice he was getting from them (Williams, 1983: 130). Of course such sources do reflect authorial biases but it is possible to compare such sources (see for example Williams (1983) for this approach). Furthermore biases themselves are instructive for revealing the mental set of important protagonists in a policy discussion.

A further important method in supplementing documentary research is the use of interviews. Thus Seldon (1996) has pointed to the value of 'elite interviews' with participants in policy making for filling gaps in documents, clarifying events by contextualising them and illuminating personal relationships which may have influenced policy. The use of interviews in this thesis was, however, not feasible because of the time gap between the events researched and the start of the research (1996). In the Chapter 2 the role of the officials in preparing the planning stage cost estimates is discussed, all had died before the research began (for details see Chapter 2).

The richness of PRO sources raise the problem of the researcher being overwhelmed by the sheer scale of documentation. However, research has been facilitated by the publication of guides to the PRO. The Land et al. text covers the period 1939-51 and the companion volume by Bridgen and Lowe covers 1951-64. Such handbooks are vital not just in pinpointing relevant Ministry of Health files but also referring to the files of other departments, particularly the Treasury and the files of the Prime Minister so that much unnecessary work locating files can be avoided.

A final limitation on the documentary research in this thesis should be mentioned, while the Service in Scotland is not ignored the primary focus is on England and Wales. This can be justified in terms of the much larger Service cost in those countries. However, it also reflects a pragmatic limitation since it has not been possible to research at the Scottish Record Office.

A distinctive feature of the method of this thesis, and one not usually used in contemporary history, is the examination of financial data and financial control concepts. A rich but underutilised source of data in this respect is that on hospital costs included in such sources

as the Hospital Yearbooks and in the Annual Reports of the Chief Medical Officer of the London County Council (LCC). Cherry (1996 and 1997) has shown how sources such as the Hospitals Yearbook can be used to illuminate the changing pattern of voluntary hospital finance in the inter-war period. However, there has been no corresponding attempt, in modern historical research, to systematically examine the hospital expenditure data contained in this source and the LCC. The thesis seeks to show the relevance of such data to the study of health policy in the period under review.

It also aims to discuss changing conceptions of financial control and key concepts used are discussed in Appendix 1. A central objective of the thesis is to show how different concepts of financial control structured the politics of NHS expenditure. The argument in this Chapter has pointed to the potential importance of cost estimates made during the planning of the NHS. Chapter 2 examines the major overall estimates prepared during the Second World War and particularly those for the General Medical Service.

Chapter Two: The Dog that didn't Bark? The General Medical Service Estimates 1942-1946

Introduction

This Chapter has two principal objectives. The first is to discuss three wartime estimates of overall NHS expenditure which will be used as points of reference not in just in this Chapter but also in Chapters 3 and 4. The second objective is to discuss estimates for the General Medical Service. The latter involves three elements: the first is the remuneration of General Practitioners (GPs) encompassing pay, practice expenses and superannuation. The second is the running costs of health centres. The third is the cost of pharmaceuticals.

This Chapter takes up a theme discussed in the Introduction, namely that 'problems' of cost control were not uniform across the Service but varied between different component parts. Broadly speaking the general practitioner (GP) component of the cost of the General Medical Service was not a source of major differences between expenditure estimates and out-turns and this point will be developed in Chapter 5 which examines the political debates relating to NHS expenditure under the Labour governments of the 1945-51 period. The thesis advanced in this Chapter is that, subject to caveats discussed below, the reason for this lack of a disjuncture between estimates and eventual expenditure lay in the mode of control of GP remuneration.

GP remuneration was designed to operate within the constraints of a cash limited pay pool. In wartime planning of a future NHS there was an intense debate on the mode of payment of GPs. This was between advocates of salary and of capitation. However, the pay pool operated so that it could accommodate *either* of these forms of payment. This meant that whereas 'salary versus capitation' was a crucial *health policy* issue it was of much more limited significance as a *financial control* issue.

While, however, problems of financial control did not loom large in this area two caveats need to be stated. The first is that the eventual decision to retain capitation as the form of payment for GPs meant that there was a greater likelihood that competition for patients could trigger problems of small list sizes and hence low pay. Medical professional support for capitation meant that such problems could only be approached by raising capitation rates which would, periodically, exert pressure to increase the pay bill. The second caveat is that pharmaceutical costs were more difficult to control because they were influenced by demand levels. Thus, while the General Medical Service did not pose major problems of financial control such problems were also not entirely absent.

The Chapter is divided into four sections. The first is designed to outline the principal overall cost estimates in wartime planning for a NHS and the context in which they were produced. The second section examines the pressure to introduce a salaried GP service from within the Ministry and, in particular, the role of Sir John Maude, Permanent Secretary to the Ministry of Health, from 1940 to 1945, in the promotion of this policy. This section discusses both the policy arguments for salary and their links to estimates of the cost of the General Medical Service between February 1942 and June 1943. The latter cut-off point is adopted because it signalled a retreat from support for salary and an increased willingness to accept a dominant role for capitation. This policy shift is discussed in the third section which analyses the response of senior Labour politicians and policy advisers to the change of direction. The section also examines the pay pool as a means of reconciling financial control with various forms of payment of GPs.

The debates on salary versus capitation are examined in the context of the cost estimates for the General Medical Services leading up to and embodied in the 1944 White Paper.

On one point they were particularly illuminating. Senior Labour politicians and policy advisers were concerned at the marginalisation of the role of group practice located in health centres; these anxieties have been discussed in the historical literature (e.g. Webster 1988a: 53; Brooke, 1992: 205-6). However neither the modern historical literature nor contemporary debates on health centres have examined the implications of cost estimates for this issue. In this section the documentary research on cost estimates is used to give a quantitative estimate of the extent to which health centres were marginalised as part of the retreat from a more collectivist view of general practice.

The fourth section discusses the cost control ‘problem’ areas within General Medical Services; the effects of the income distribution generated by the capitation form of payment for overall GP pay costs; and the costs of pharmaceuticals. It explores the basis for the support for capitation from the (1946) Spens Committee on GP remuneration and looks at statistical data on the distribution of GP incomes to explore how far capitation was linked to a ‘problem’ of low incomes. It also seeks to reconstruct the basis for estimation of pharmaceutical costs and considers the cost control problems which stemmed from such estimates.

The conclusion shows that there was a major disjuncture between the health policy and financial control dimensions in this part of the Service. In health policy the debate over the form of payment of GPs had a high political profile. However, the operation of the pay pool meant that financial control problems were relatively insignificant.

Wartime Estimates of Overall Service Costs

In this section the aim is to examine the major cost estimates used in wartime planning for a future NHS. Three major estimates are discussed. The first is the *Approximate Cost*

of the *Main Health Services* (henceforth 'Approximate Cost') of July 1942. It is considered because it formed the basis for the cost estimate in the Beveridge Report. The second is the *Finance of New Health Scheme* estimate of September 1943. It is particularly significant because of the link to two important policy changes. The first was the retreat from a health centre based GP service which is discussed later in this Chapter. The second is the sharp downward revision in the cost estimates for the Dental and Ophthalmic services which are discussed in detail in Chapter 3. The third estimate is that in the 1944 White Paper, *A National Health Service*. This estimate, as well as its significance in a major policy document, formed the basis for the first major *post-war* estimate in the 1946 Financial Memorandum to the NHS Bill.

Four key officials were involved in discussion on these estimates and it will be useful to identify them at this point. The Permanent Secretary (1940-1945) was Sir John Maude, he played a particularly crucial role in discussion of the form of GP pay. After his retirement from the Service he was a member of the Guillebaud Committee whose findings are discussed in Chapter 6 and he died in 1963 (Webster, 1996: 782). Maude frequently discussed his ideas on the form of payment for GPs with an Assistant Secretary, with long administrative experience of National Health Insurance (NHI), Hervey (later Sir Angus) de Montmorency known as 'Demo' within the department (Honigsbaum, 1989: 15), he died in 1959 (Who was Who, 1961). Wartime estimates were principally prepared by H.H. George, (Honigsbaum, 1989: 41-2), as Accountant-General he also played a major role in preparing the post-war estimates and his testimony before the Select Committee on Estimates, with respect to these post-war estimates, is discussed in Chapter 5, he died in 1982 (Who was Who, 1991). George frequently

discussed the wartime estimates with Sir George Epps, the Government Actuary (Honigsbaum, 1989: 41-2). He prepared the financial estimates in the Beveridge report and died in 1951 (Who was Who, 1961).

A starting point for a discussion of these estimates is the Beveridge Report and the link between the preparation of the Report and the cost estimates is outlined below.

The Significance of the Beveridge Report

As was argued in the Introduction, Beveridge's interest in health related to his goal of structuring a broad post-war social settlement. However the narrower role of the Report, as effecting a transformation of the British system of income maintenance, also raised important issues of health policy.

A major feature of the proposals in the Beveridge Report was that benefit levels were to be pitched at a significantly higher level than those prevailing at the end of the inter-war period. The increase was particularly striking in the case of sickness benefit. For example, for men 21-65, the prevailing benefit level in 1942 was 18/- (90p) a week and this was paid without any allowance for children or dependants. In contrast the rate for men of the same age range in the General Unemployment Insurance scheme was £1 and there was a 10/- (50p) allowance for a 'wife or other adult dependant'; and 4/- (20p) for the first and second child (Cmd. 6404: 230). In contrast, in the Report, Beveridge proposed a unified rate for unemployment and sickness benefits (termed 'disability' benefits in the Report) because 'there is no difference between the subsistence needs of those affected by different forms of interruption of earnings which is large enough to justify a differentiation of benefits' (ibid.: para. 123). Thus Beveridge proposed a common benefit level of £2 for a man and 'not gainfully occupied wife' with 8/- (40p)

children's allowance for each child for those in receipt of benefit (*ibid.*: para. 401). Thus, for a man 21-65 with two children and an 'economically inactive' wife benefit while off work due to sickness would increase from 18/- (90p) to £2 16/- (£2.80p).

As a corollary Beveridge was concerned that there be a reliable system of certification for sickness and disability as a barrier to abuse (Note of a Meeting Held 17th February 1942, PRO, MH 80/31). This was an indication of Beveridge's concern with cost control issues. Equally, as will be indicated below, this question figured in debates on the appropriate form of the employment relationship between GPs and the state. Beveridge wanted a universal insurance scheme and this contrasted with inter-war insurance schemes which operated with income limits. Under the inter-war National Health Insurance (NHI) system GPs usually combined NHI 'panel' patients with private patients (Digby and Bosanquet, 1988). Beveridge's proposals carried the implication of the possible marginalisation of private practice. Again this would have implications for the nature of the employment relationship between GPs and the state and for pay levels (Note of a Meeting Held 17th February 1942, PRO MH 80/31).

Beveridge's intervention gave a strong impetus to wartime planning for a post-war national health service. To a considerable extent this related to fears, within the Ministry, regarding his influence. Thus, in a letter of 9th February 1942, Maude wrote '...I feel pretty sure that we must...work out some sort of scheme for a general medical service if only for the reason that in its absence Beveridge, who is thirsting to do the job himself, will probably induce Greenwood to make him report on the subject' (Maude to 'Demo', 9th February 1942, PRO, MH 80/31). Greenwood, a former deputy leader of the Labour Party was then chair of the Reconstruction Problems Committee (Land et al., 1992: 4).

The Approximate Cost Estimate of 29th July 1942 (PRO, MH 80/24) formed the basis for the health service cost figure in the Beveridge Report. As can be seen from Table 2.1 this figure (rounded up) would give £120 million annual expenditure whereas the figure included in the Beveridge report was £170 million (Cmd. 6404: para. 268). Part of the reason for the discrepancy was that this estimate, along with the others cited in Table 2.1, were for England and Wales whereas the Beveridge report estimate was for Great Britain. There was also an adjustment to take account of inflation. The inflation adjustment was 25% and this pushed the expected cost figure up to £150 million, a further £20 million was added for Scotland to give the Beveridge figure (George to Hale, New Health Service, 2nd March 1943, PRO, MH 80/25).

The second estimate shown in Table 2.1 is the Finance of New Health Scheme of 24th September 1943 (PRO, MH 80/26). It is particularly important to note, with respect to this estimate, the sharp downward revision in Dental and Ophthalmic estimates when contrasted with the Approximate Cost figures and that this revision was carried into the 1944 White Paper estimate. The policy issues relating to this change will be discussed in detail in Chapter 3. The final estimate is that in the White Paper. It is important here to contrast the figure given for hospital expenditure of roughly £80 million (adding the voluntary hospitals, mental/mental deficiency hospitals and hospitals other than mental/mental deficiency). This is significantly higher than, in particular, the Approximate Cost estimate which was £52.2 million, these changes and their significance are discussed in detail in Chapter 4. In this Chapter the focus is on the General Medical Service and an essential background to the estimates is provided by the health policy debates around the form of payment of GPs.

Table 2.1 Selected Overall Health Service Cost Estimates 1942-4 (England and Wales).

Service	Approximate Cost Estimate, 29/7/42	Finance of New Health Scheme Estimate 24/9/43	White Paper Estimate, February 1944
Hospitals (other than mental/'mental deficiency')	£ 27,000,000	£ 50,000,000	£ 49,700,000
Mental/'Mental Deficiency' Hospitals	£ 14,500,000	£ 19,000,000	£ 20,300,000
Maternity/Child Welfare	£ 3,500,000	£ 5,000,000	£ 6,000,000
Nursing	£ 1,000,000	£ 1,000,000	£ 1,000,000
School Medical	£ 3,000,000	-	-
Voluntary Hospitals	£ 10,700,000	*	£ 10,000,000
General Practitioners	£ 35,000,000	£ 33,000,000	£ 30,000,000
Dental	£ 20,000,000	£ 10,000,000	£ 10,000,000
Ophthalmic	£ 2,000,000	£ 1,000,000	£ 1,000,000
Cancer Act	-	£ 1,000,000	**
Midwifery	-	£ 1,800,000	£ 3,000,000
Clinic (running costs)	***	***	£ 1,000,000
Total	£116,700,000	£121,800,000	£132,000,000

Sources: Approximate Cost of the Main Health Services, PRO, MH 80/24; George to Maude, Finance of New Health Scheme, 24th September 1943, PRO, MH 80/26; Cmd. 6502.

***included under hospitals other than mental/mental deficiency**

**** included under hospitals other than mental/mental deficiency**

*****included under General Practitioners**

Salary versus Capitation

The Case for Salary

In the inter-war period, under National Health Insurance, GPs were paid on a capitation basis, i.e. they received a fee for each patient on their list (details of changes in capitation rates under NHI are given in Digby and Bosanquet, 1988: 76). However, as Honigsbaum (1989) has pointed out, Sir John Maude was a strong and consistent advocate of salary as the preferred form of payment for GPs. Maude had transferred to the administrative side of the Ministry in 1934 as an Assistant Secretary (Honigsbaum, 1979: 334) but previously he had worked in the solicitor's department. His role as a solicitor dealing with disciplinary issues influenced (see below) his approach to the appropriate form of payment for GPs (Honigsbaum, 1989).

Maude produced a paper in March 1942, *Post-War Medical Policy – General Practitioner Service*, (PRO, MH 80/31) which was, in effect, a critique of the NHI panel system and case for a salaried GP service. He argued that panel practice threatened standards in primary care in a number of ways. Entry to the panel was open to any medical practitioner but removal could not occur 'in the absence of legal proof of serious misconduct or incapacity' (ibid.). As the doctor was an independent practitioner there was effectively no supervision of standards. A case made for panel practice was that, as GPs were paid on a capitation basis, then standards of practice would improve via the impact of competition for patients. However Maude argued that 'patients and in particular working class patients cannot distinguish good treatment and bad' (ibid.). Thus competition for patients was not seen as a substitute for supervision of medical practice.

All these considerations have connections with Maude's experiences with disciplinary issues and standards of practice in the Ministry.

Furthermore, the capitation system and competition for patients were seen as having negative effects since they led to 'wasteful prescribing and lax certification' (ibid.). This view was not peculiar to Maude. 'Demo', in a letter to Maude of 23rd February 1942, (PRO, MH 80/31) argued that in 'more than one case' doctors had explained standards of certification which they admitted were indefensible by reference to fact that they could not 'set a higher standard than [a] competitor in the next street'. Beveridge shared this view arguing that '...from the point of view of control and adequate cash benefits community service appears preferable to the panel' (Beveridge, Some Problems of Medical Treatment, 4th February 1942, PRO, MH 80/31). 'Community service' was Beveridge's term for salaried practice. 'Demo' also thought that over-prescribing was encouraged by competition for patients since '...the doctor who sends his patient away with good advice but no bottle runs a serious risk of losing him' ('Demo' to Maude, 23rd February 1942, PRO, MH 80/31).

Inter-war general practice had also operated with no restriction on the right of GPs to take private in addition to panel patients. Maude argued that such a combination threatened standards in the public service because 'the right to carry on private practice makes it impossible to ensure that the doctor gives or can give adequate attention to his panel patients' (Maude, Post-War Medical Policy – General Practitioner Service, PRO, MH 80/31).

The emphasis in Maude's argument on supervision and salary implied a pay structure which linked competence and experience to pay. This was connected with a further

objection to panel practice. In the inter-war period GP practices were bought and sold and practice 'goodwill' varied both with patient numbers and variations in fee income from private patients (Digby and Bosanquet, 1988: 81). However, under such a structure, the links to experience and competence could not be maintained: '...a young man fresh from hospital' could purchase a practice which could '...produce him an immediate income comparable with that of a senior medical officer in the Government or Local Government Service'(Post-War Medical Policy – General Practitioner Service, PRO, MH 80/31). Again this was common ground between Maude and Beveridge. Thus in his paper *Some Problems of Medical Treatment* (PRO, MH 80/31) Beveridge had argued that 'community service' was '...consistent with adjusting the remuneration of individual doctors both the amount and to the difficulties of the work'. It is now necessary to examine how these arguments on the respective claims of salary as against capitation were reflected in the cost estimates. The first major estimate considered is the Approximate Cost estimate.

The Approximate Cost Figure

As was indicated in Table 2.1, that estimate gave an expected cost for the General Practitioner (GP) service of £35 million per annum. A fairly comprehensive source for this figure can be found in Maude's *Post-War Medical Policy: General Practitioner Service* paper (March 1942, PRO, MH 80/31). The breakdown of this overall figure, using data in this document is given in Table 2.2.

**Table 2.2 Breakdown of Expected Costs of the General Practitioner Service:
February 1942 Estimate (England and Wales).**

Salary – Doctors	
15,000 annual salary £800 per annum - £12 million	
6,000 annual salary £1,300 per annum - £7,800,000	£19,800,000
Clinic Costs (per clinic):	
Rent £150 per annum	
Heating £75 per annum	
Equipment £50 per annum	
2 Nurses £400 per annum	
2 Clerks £400 per annum	
Total £1,200* per annum per clinic	£ 4,920,000
Medical Administration	£ 1,230,000
Drugs	£ 5,000,000
Superannuation	£ 3,500,000
Overall Total	£34,450,000

*individual items added are £1075 but an overall £1200 figure is cited.

Source: Maude, Post-War Medical Policy – General Practitioner Service, February 1942, PRO, MH 80/31.

The expectation that doctors would be paid by salary is clear from the Table. As might be anticipated the largest share of the overall cost was accounted for by remuneration of doctors, salary (£19.8 million) and superannuation (£3.5 million). The salary figure involved two assumptions; one relating to the number of GPs expected to be needed in the new service; and the other relating to their pay levels. Maude's paper assumed that the GP service would be made available to the entire population and that utilisation would be virtually universal 'perhaps 95%' (Post-War Medical Policy – General Practitioner Service, PRO, MH 80/31). This meant that, as the estimate was for England and Wales, a service available to a population of 41,250,000 (Mitchell and Deane, 1971)

was required. To derive GP numbers a norm for list size was required and a 2,000 list was presupposed. This literally gave a figure of 20,625 GPs but it would appear to have been rounded up to 21,000 in the document.

As the Table indicates, a two grade structure was envisaged with 15,000 doctors earning £800 per annum and the other 6,000, £1,300 and this was the basis for the overall salary figure given. In addition to the assumption that GPs would be salaried the calculation operated on the basis that general practice would operate from clinics with group practice of 5-6 doctors per clinic. This was consistent with Maude's support for group practice from health centres as embodying the virtues of teamwork as against competition. It is also important to note that the figures imply *universal* coverage for health centre practice. Each clinic was to serve a population of 10,000. As the Table shows, clinics were assumed to cost £1,200 per annum to run (excluding GP salary) and the total cost figure (£4,920,000) would be sufficient to finance 4,100 clinics. This, in turn, on the 10,000 population per clinic ratio would be sufficient to cover the entire population of England and Wales (41,000,000).

The cost of 'medical administration' was for a senior medical grade with a supervisory role with respect to clinics. The document states that 3 'administrators' paid an annual salary of £2,000 would be responsible for a population of 200,000. Taking the clinic norms presupposed this meant that each administrator would cover 6-7 clinics. Given complete population coverage roughly 620 administrators would be required and a £2,000 salary would be the basis for the £1.2 million figure cited.

Another important feature in the cost calculations of this period was the attempt to locate GPs within a salary framework which set remuneration a comparable level with

other doctors in public service. This was consistent with Maude's objective of turning GPs into public servants. This is illustrated in Table 2.3 which is adapted from a paper of March 1942 (Hawton, National Health Service – Remuneration of Doctors, March 1942, PRO, MH 80/31). The Table shows some of the public service medical posts seen as comparable with GPs at different putative grades.

Table 2.3: Proposed General Practitioner Salaries (1942) and Comparisons with other Salary Levels in the Public Medical Service.

General Practitioners	Ministry of Health	Board of Education	London County Council	Middlesex County Council
Assistant Medical Officer - £400				Junior Medical Officer - £400
Medical Officer - £650-1,300	Medical Officer - £850-1,200	Medical Officer - £738-£1,100	Divisional Medical Officer - £800- £1,000	Surgeons, Physicians (lower scale) - £650-1,000
Medical Officer (in charge of clinic) - £1,400	Regional Medical Officer - £1,100-£1,400	Senior Medical Officer - £1,300- 1,400	Senior Medical Officer (lower scale) £1,200- £1,300	Surgeons, Physicians (higher scale) - £1,000 – 1,500
Senior Medical Officer - £1,600	Senior Medical Officer - £1,400-1,600	Principal Medical Officer - £1,700-2,000	Senior Medical Officer (higher scale) £1,300- £1,600	Medical Superintendant (higher scale) - £1,550-1,700

Source: Hawton, National Health Service – Remuneration of Doctors, March 1942, PRO, MH 80/31.

The Finance of New Health Scheme Estimate

The Finance of New Health Scheme document, of September 1943, gave a slightly lower figure of £33 million per annum for the General Practitioner Service. A considerable amount of detail on the derivation of this figure is to be found in *GP Service* a subsection of the longer *New Health Service* document, drafted by George, of 26th February 1943 (PRO, ACT 1/708) and, again, it is clear that payment via salary was presupposed. In this document, as Table 2.4 indicates, a three grade structure was proposed with an Assistant

grade at the bottom, a Principal and a Medical Administrator grade at the top. The Table shows that the Assistant and Medical Administrator grades were at a fixed salary level with the Principal grade paid on a salary scale.

Table 2.4: Estimates of the Cost of the GP Service Reconstructed from Documents of February and May 1943.

Salary – Doctors	
Assistants - £400 per annum, 1830, - £732,000	
Principals - £650-1,300, 17,800 – £17,676,000	
Medical Administrators - £1,700 per annum, 370- £592,000	£19,000,000
Clinics 3,000 at £2,000 per annum each	£ 6,000,000
Transport	£ 2,000,000
Superannuation (5 % of salary)	£ 1,000,000
Drugs	£ 5,000,000
Total	£ 33,000,000

Source: New Health Service and Epps to George 28/5/43, PRO, ACT 1/708.

The *GP Service* document does not attach numbers to the individual grades but guidance on what was anticipated can be obtained by using data in a letter from Epps to George (28th May 1943, PRO, ACT 1/708). This assumed (see Table 2.4) 1,830 assistants, 17,800 principals and 370 medical administrators. This implied a slight fall in GP numbers to 20,000 and a corresponding increase in list size.

If the figures in the letter to Epps are taken then it is possible to attempt a reconciliation of the overall cost figures with the expected salary levels. As Table 2.4 shows, the Assistant and Medical Administrator grades would, given the assumed numbers, cost respectively £732,000 and £592,000 per annum. This would leave £17,676,000 . Thus the de facto average salary for the Principals, who were to make up the bulk of the profession would be £1,000 per annum.

The costs of clinics had increased substantially to an average cost of £2,000 per annum. No detail is provided on this shift but, for example, Epps had complained to Maude that his figure for equipment (£50 per annum in effectively a 5 doctor clinic and thus £10 per doctor per year) was unrealistically low (Epps to Maude, 23rd March, 1942, PRO, MH 80/31; Honigsbaum, 1989: 44). However, while the cost of individual clinics was increased clinic numbers were cut to 3,000.

Perhaps reflecting another criticism by Epps (in the same letter) an item for transport was included at £2 million. The superannuation figure was significantly lower and was based on a 5% of salary contribution rate. In this document the 'medical administration' cost was not entered. This could have been because this role was now assumed by the 'medical administrators' as the highest GP grade in the new three grade structure.

The Retreat from Salary

The two detailed estimates for the General Medical Service cited both presupposed salary as the principal form of payment, but this was a policy likely to be unpopular with doctors. An important element in GP resistance was hostility to employment under local government and salary was linked to local government employment by the Ministry because, as Honigsbaum (1989: 42) has pointed out, the 'Ministry staff saw themselves as the main spokesmen for municipal interests in Whitehall'. This was reflected in an assumption that a national health service would be run by local government. Equally, if this was to be the case then an integrated service required that municipal control must extend to GPs (*ibid.*). Equally Digby (1999: 301) has shown that, whereas in the Victorian and Edwardian periods, GPs frequently took up part-time posts as Medical Officers of Health (MOH), trends changed dramatically in the inter-war period. With the

expansion of local authority health services in that period increasingly MOH appointments were full-time (ibid.: 301). This separation between GPs and public health engendered a series of tensions: local authority domiciliary services were expanding (ibid.) but also were a potential alternative to those offered by GPs (ibid.: 302; see also Lewis, 1986); and the MOH was seen by GPs as being ultimately under the local authority lay bureaucracy (Digby, 1999: 301).

The distrust of the MOH was, in part, linked to what was seen as undue lay influence over medical practice. However, there was also medical resistance to supervision by medical practitioners *not* in full-time state employment. In attempting to explore this issue, in September 1942, Maude had written to Jameson, the Chief Medical Officer, asking for a paper ‘...on the degree of control over a doctor to be expected’ and that this paper should be ‘written from the point of view of a medical man’ (Maude to CMO, General Practitioner Service, 26th September 1942, PRO, MH 80/24; Honigsbaum, 1989: 45). Jameson asked Dr. M.U. Wilson, a doctor with a broad experience both as a GP and in the school medical service, to give a view. In his reply he reviewed practice in a variety of settings and concluded that ‘...complete freedom of clinical judgement and action is envisaged even for junior members of the profession’ (Wilson to CMO – General Practitioner Service, 2nd October 1942, PRO, MH 80/24; Honigsbaum, 1989: 45).

In his letter Wilson suggested that any admission of the legitimacy of a clinical supervisory role would only be conceded where the supervising doctor has a superior status which was accepted. (Honigsbaum, 1989: 138). Given the tensions between MOHs and GPs discussed earlier the MOH would not have been seen as a doctor of such a superior status. In addition MOHs were resistant to the participation of GPs in health

policy decisions because they saw themselves as the official advisors to the local authority (Honisgbaum, 1989: 193).

Notwithstanding this potential for conflict with the profession Maude pressed on with the policy of a salaried GP service under local authority control. One mechanism which he used in an attempt to defuse criticism was the proposed creation of a hybrid employment relationship for GPs. This involved a Central Medical Board (CMB) which was to be medically dominated but with some lay representation. This body would determine whether a doctor could enter the public service and it would also have other key roles in the employment relationship. If the local authority considered the doctor 'unfit for the Public Medical Service' then it would make representations to the CMB who, after inquiry, could remove the doctor from the Service. In less drastic cases, when the contract 'was terminated otherwise than by removal from the Service'; the CMB would seek to find the doctor alternative employment and, failing this, the doctor would be entitled to 'some kind of unemployment pay or subsistence' (Maude, Post-War Medical Policy – General Practitioner Service, PRO, March 1942, MH 80/31).

However, these proposed arrangements still involved the control of GPs by the local authority and resistance by doctors involved conditions which engendered a stalemate with local authorities. Thus, a report of a meeting between representatives of the doctors and officials in March 1943 stated that 'the professional representatives said strongly that the profession would object to being under local authorities unless there were adequate medical representation on them' (First Meeting with the Representative Committee of the Medical Profession, March 1943, PRO, MH 80/31). However, such a

demand was, in turn, unacceptable to local authorities on the grounds that it involved determination of policy by non-elected individuals (Honigsbaum, 1989: 55).

The upshot of this block to progress was a change of policy by Maude. The precise causes are not entirely clear (see Honigsbaum, 1989:58-9). However an important change of direction is clear by June 1943. In a paper of 7th June 1943 *General Practitioner Service* (PRO, MH 80/31) Maude envisaged a plan of a 'system of group practice in centres' which would be 'carried on simultaneously with the present panel system or some modification of it'. This would also require that 'remuneration under the two systems would broadly correspond'.

The Pay Pool

This retreat to a combination of health centre practice with the panel system required a new pay structure since 'panel practice' meant capitation. A proposal to this effect came from George in a paper of 8th June 1943 (George, Remuneration of Doctors, 8th June 1943, PRO, MH 80/31). In the paper George proposed a basic salary to be payable as long as the doctor's list did not fall below 1,000 (ibid.). This paper is very important for illustrating the role of a *funding pool* in the remuneration of GPs. In the paper George proposed a distribution formula for GP pay. This was to work in the following way: 'X' was to represent the 'total fees' for distribution; 'Y' was the cost of the basic salary referred to above; 'X-Y' was the funding remaining after the deduction of salary. In turn this would go to doctors whose list was too small to qualify for salary; and also to doctors who did qualify as an addition to salary. This money was to be distributed on a capitation basis but doctors working from health centres would be paid at a fee level one third below the capitation level applying outside such centres (ibid.). The rationale for this

reduction was that practice expenses, which would be met by the doctor in 'panel' practice, would be financed as part of the running costs of the clinic and would thus fall on public funds in health centres. What it is important to note in this 'formula' is that the *form of pay* is seen as independent of the *total level of funding*, 'X'. 'X' could be distributed as salary (as had originally been envisaged in the first two estimates discussed above); through a combination of salary and capitation (as in George's July 1943 paper); or mainly as capitation payment (the scheme eventually adopted under the NHS). Thus the operation of 'X' meant that GP remuneration did not pose, at least in the short term, a problem of financial control whatever pay system was adopted. Various pay systems could be fitted into the overall funding limit and the pay ceiling was divorced from demand for the service since, for example, it did not vary with patient consultation rates.

Labour and the Retreat from Salary

However, as has already been indicated, Maude's arguments showed that key issues of health policy were at stake in the choice between salary and capitation. These included questions relating to standards in the General Medical Service; to relative standards of service for public and private patients; and to the model which was to apply to general practice, 'competitive' (retention of the panel) or 'non-competitive' (group practice in health centres). As the retreat from salary materialised these issues were taken up by senior Labour politicians and their advisers.

An indicator of the extent of the movement away from salary can be seen in a memorandum to the Cabinet Committee on Reconstruction Priorities from the Minister of Health (Brown) and the Secretary of State for Scotland (Johnston). This stated 'for the present purposes we assume that the new general practitioner service is to be envisaged

as largely (almost wholly at first) based on the “panel” doctor rather than the principle of grouped and non-competitive practice in publicly provided health centres’ (War Cabinet: Committee on Reconstruction Priorities, National Health Service: General Practitioner Service, Memorandum from the Minister of Health and the Secretary of State for Scotland, 9th October 1943, PRO, CAB 87/13).

In a meeting of the Committee soon after the submission of the Memorandum (15th October 1943) Attlee (then Lord President of the Council) raised his concerns that it was now proposed to ‘base the service on the old system of the panel’ rather than ‘non competitive practice in publicly provided health centres’ (War Cabinet: Committee on Reconstruction Priorities, Minutes, 15th October 1943, PRO, CAB 87/12). An insight into the basis of Labour concerns regarding this retreat can be gained from looking at advice on health policy, given to Attlee, by Evan Durbin, later Parliamentary Secretary to the Ministry of Works who died in an accident in September 1948 (Brooke, 1996); and William Piercy, a Labour supporter and businessman (Williams and Nichols, 1981) both were, at the time, acting as assistants in Attlee’s office. The problems raised by the retention of the panel have to be set in the context of fears relating to the effects of allowing doctors in public service to combine public with private practice (again replicating panel practice where limits on coverage had created substantial scope for private practice, see Digby and Bosanquet, 1988).

This not only raised the issue, which had concerned Maude, of GP commitment to public service and the possibility of dual standards (Piercy and Durbin, National Health Service: a Note on PR (43) 46, William Piercy Papers (henceforth WPP) 8/20, 13th August 1943) but also the possibility that the public general medical service could be

seen as inferior and residual. This risk was seen to stem from the fact that, if doctors in public service took paying patients, this carried the implication that there was an advantage in paying (Piercy and Durbin, Draft White Paper on the New Health Service, WPP 8/20, 4th January 1944; also see Digby, 1999: 318 for concerns that 'panel' practice involved inferior standards for NHI patients in the inter-war period).

As socialists Piercy and Durbin were also anxious that health centres which embodied a 'non competitive' approach to general practice were being marginalised. These concerns were related to a move to treating health centres as 'experimental' in the sense of a small scale initiative whose value could then be evaluated. In contrast Piercy and Durbin thought that, while there was scope for investigating 'the best arrangements for group practice in varying circumstances', this should go along with a substantial health centre programme which should 'begin immediately' (Piercy and Durbin, Draft White Paper on the New Health Service, WPP 8/20, 4th January 1944; see Hansard, House of Lords Debates, Vol. 140, Col. 846 for Piercy's later support for health centres).

This critical perspective on the drift away from salary and health centres was endorsed by senior Labour politicians. At the Reconstruction Committee, in discussions of the draft White Paper, a series of criticisms of this policy change were advanced. Attlee raised the problem of dual public/private standards if doctors in the public service were allowed to take private patients and he thought that GPs should be obliged to opt for either public or private practice. Both Morrison and Bevin stressed the need to press ahead with a policy of establishing health centres; and Morrison wanted the 'principle of salaried service' extended 'as rapidly as possible' (War Cabinet: Reconstruction Committee, Minutes of a Meeting of the Committee held 12th January 1944, 12.0, PRO, CAB 87/5).

Labour opposition to what was seen as the abandonment of salary and health centres were justified by reference to the key formulations in the White Paper and it was accepted by senior Labour politicians only with great reluctance. Thus the Reconstruction Committee Chairman, Lord Woolton, told Eden, in February 1944, that Attlee was expressing 'considerable dissatisfaction with the compromise' (cited in Brooke, 1992: 207). The reasons for Labour's reluctant acquiescence can be understood if some key statements in the White Paper are considered. The White Paper did endorse payment of GPs by salary in health centres: 'there is a strong case for basing future practice in a Health Centre on a salaried remuneration or some similar alternative which will not involve mutual competition in the Centre' (Cmd. 6502: 32). However, this was qualified because health centre doctors were to be able to take private patients thus introducing the element of competition into health centres (ibid.: 31). Outside health centres in 'separate practice' remuneration was to be based on capitation (ibid.: 32).

As salary, and, as far as it was viable, non competitive general practice was dependent on health centres a crucial issue was how significant they would be in a future General Medical Service. Again the position taken in the White Paper was far from the Labour ideal of health centre practice as the norm. It was argued that health centres were to be given a 'full trial' and such a 'trial' would enable them to be 'developed as time goes on to the maximum extent which the practical experience of its working is found to justify' (ibid.:30). This formulation was consistent with a long-term marginal role for health centres and thus for salary.

Labour doubts on the marginalisation of health centres were primarily related to *textual* formulations which suggest that health centres were merely to be 'tried out' alongside a

continuation of panel practice (see for example Piercy and Durbin, Draft Paper on the New Health Service, WPP, 8/20, 4th January 1944). However, research on the cost estimates opens up a new perspective on the marginalisation of health centres since it allows an estimate of the numbers of such centres which were envisaged and the expected population coverage.

In the *Finance of New Health Scheme* document, a *Note 5* is appended (PRO, MH 80/26). In this *Note* there is an interesting change in the costing of clinics. As was pointed out above, Epps had complained to Maude regarding the parsimonious level of funding for clinics assumed in the Approximate Cost figure. In the *Note* George referred to another source of criticism, from local authorities the bodies designated to run such centres. George stated that local authorities representatives had cited an annual running cost figure of £6,000 or five times the estimate given in the Approximate Cost estimate. No precise source for this figure has been located. However, in a report of a meeting between Ministry officials and local authority representatives in July 1943, Mr Lythgoe, an Association of Municipal Authorities representative, is said to have 'quoted figures on running and maintenance costs...on a much higher scale than those envisaged for the new health service clinics' (Fifth Meeting with Representatives of Local Authorities, 27th July 1943, PRO, MH 80/31).

George seemed willing, at least for illustrative purposes, to accept this figure and he included a table in another note, *Note D* which showed the impact on the costs of the GP service of different levels of clinic coverage, this is reproduced as Table 2.5

Table 2.5 Cost Estimates of GP Service Making Different Assumptions Regarding Clinic/Health Centre Coverage

Clinics	Doctors' Remuneration	Clinic Cost	Drug Cost	Total Cost
0	£24,661,000	-	£ 5,000,000	£29,661,000
100	£24,496,000	£ 600,000	£ 5,000,000	£30,096,000
500	£23,839,000	£ 3,000,000	£ 5,000,000	£31,839,000
1,000	£23,017,000	£ 6,000,000	£ 5,000,000	£34,017,000
2,426	£20,015,000	£14,508,000	£ 5,000,000	£39,718,000

Source: George, Finance of New Health Scheme, 24th September 1943, MH 80/26.

What is clear is that while there was some saving via lower capitation payments to doctors in scenarios with extensive clinic coverage (reflecting public funding of practice expenses). This was greatly outweighed by the escalating running costs of clinics at the new higher rate.

The White Paper Estimates

If these new expected running cost figures are set in the context of the White Paper estimate for General Practitioner services then the extent of the move away from a universal health centres policy can be seen. In the White Paper a further reduction is made in the estimate, to £30 million annual cost but no breakdown is given for this figure. However, in the first draft of the White Paper financial appendix (attached to a letter to Maude of 5th November 1943, PRO, MH 77/28). George gave the following figures which are reproduced in Table 2.6.

Table 2.6: Estimate of the Cost of the General Practitioner Service (First Draft of the Financial Appendix, November 1943)

Fees to General Practitioners	£24,000,000
Superannuation	£ 1,800,000
Fees to Chemists	£ 6,000,000
Total	£31,800,000

Source: George to Maude, First Draft of the Financial Appendix, 5th November 1943, PRO, MH 77/28

A major difference here, with respect to previous estimates, is the absence of any figure for clinic running costs. In the published version of the White Paper they were reclassified with the clinic, midwifery and health visiting services provided by counties and county boroughs and an estimate of £1 million was given (Cmd. 6502:82; see Table 2.1). If we assume the running cost figure of *Note 5* of £6,000 per annum per centre this would fund 160 centres as against the 4,100 originally envisaged in the Approximate Cost estimate. For example with five doctors per clinic with roughly 2,000 lists each only a population of 1,600,000 could be covered, just under 4 *per cent* of the population of England and Wales and hence consistent with a ‘small trial’ conception of health centres. It is also worth noting that this is roughly in line with the salary figures in the *Note* thus with 100 clinics doctor remuneration would amount to £24,496,000 and rounding down would give the draft financial appendix figure.

The ‘Problem’ Areas: the Costs of Pharmaceuticals and the Long-Term Effects of Capitation

As was indicated above, the effect of a pay pool meant that neither the form of payment adopted nor the level of service demand would affect GP remuneration. This meant that the service area was likely to prove one of the least problematic from a cost control standpoint. However, this did not mean that cost control in General Medical Services was

unproblematic. The aim of this section is to discuss the two areas in which cost control problems were a feature: the long-term effects of a capitation based pay system and the cost of pharmaceuticals

Capitation and the Distribution of General Practitioner Incomes

The first problem area relates to the longer term effects of capitation as the principal element in GP remuneration. As was argued in the last section, support for capitation could be argued to be implicit in the White Paper but, after the War, an Inter-Departmental Committee on the Remuneration of General Practitioners, chaired by Sir Will Spens, was appointed to make recommendations on GP remuneration under the NHS. Strictly the form of remuneration (as against its level) was outside the remit of the Committee (see, for example, Cmd. 6810: para. 2). Equally the Report appeared to take an agnostic line on this issue. Thus it stated ‘we are only directly concerned with what remuneration a general practitioner ought to receive not with the method or basis of...payment’ (ibid.: para. 13). However, the Report is full of de facto support for capitation. Thus capitation was described as ‘...the most obvious method of securing such variations in income as are necessary if different degrees of ability, effort and work are to be suitably remunerated’ (ibid.). Similarly there was a negative attitude towards salary thus it was stated ‘...we are satisfied that a single salary scale, applicable to all, would be inappropriate with so great a variety of ability and effort which necessarily exists in such a profession as that with which we are concerned’ (ibid.: para. 15).

This support for capitation reflected the influence of the British Medical Association (BMA) over the Spens Committee. Webster (1990b: 205) has pointed out that half of the Committee were GPs nominated by the BMA. However, the Committee also pinpointed

low pay amongst a significant proportion of GPs as a major problem (Cmd. 6810: paras. 8 and 10). Webster (1990b: 207) has argued that this involved it in an inconsistency since capitation might be expected to be more likely to generate inequalities in income reflecting differences in list size. Table 2.7 suggests support for Webster's argument.

Table 2.7 Lower Quartile Income Levels as a Percentage of Median Earnings, Male General Practitioners, 45-54, 1936-8 and 1955-6.

Year	Lower Quartile Earnings as a Percentage of Median Earnings
1936-8	71.6%
1955-6	77.0%

Sources: Bradford-Hill (1951); Cmnd. 939.

The 1936-9 figure is drawn from the survey of GP income undertaken by Professor A. Bradford-Hill which was commissioned by the BMA and was a key source for the Spens Committee (on this importance of this source see Cmd. 6810: para. 6). This is contrasted with data for 1955-6 from the Report of the Royal Commission on Doctors' and Dentists' Income (Cmnd. 939). This data is for GPs 45-54 and this age group was selected because it represents the peak earnings level for GPs in both surveys. The lower quartile level as a percentage of the median is treated as a simple indicator of the extent of a 'low pay' problem. What is interesting is that, while there is a reduction in the extent of 'low pay' using this proxy, it is relatively limited.

The commitment to capitation could thus be argued to have been an obstacle to tackling low pay directly via a suitably adjusted salary scale. It also had implications for overall pay levels. Thus Webster (1990b: 210) argues that the deficiencies of capitation meant that the BMA came 'under siege from the underprivileged classes of its membership'. However, being tied to capitation its only option to 'assuage the poor without offending the rich' was to press for a general increase in remuneration via a higher capitation fee

(ibid.). Thus, while the funding pool meant that rapid and unanticipated disjunctures between estimates and out-turns did not characterise GP remuneration it can be argued that capitation, by virtue of its inequalitarian effects may have created the basis for periodic pressure for substantial increases. In the period under consideration in the thesis this resulted in BMA pressure for a higher capitation rate which was reflected in the Danckwerts pay award to GPs of 1952 (Webster, 1990b).

Pharmaceutical Costs

The second problem area was pharmaceutical costs. They were estimated at £5 million in both the Approximate Cost and the Finance of New Health Service documents and at £6 million in the White Paper (see Table 2.1). There is a consistent dearth of data in the PRO records relating to how these figures were derived. This, in turn, reflects a limitation of documentary research discussed in the Chapter 1. Particular approaches to the estimates may have been discussed verbally and not included in any documentary form (Land et al., 1992: x). Failing explicit evidence on how these figures were derived it is possible to attempt a reconstruction of the estimate. As was pointed out earlier in the Chapter both Campbell (1987) and Klein (1995) have suggested that NHS cost estimates rested on extrapolations from earlier cost figures. This possible explanation is here applied to the pharmaceutical cost figures in Table 2.8.

Table 2.8: Reconciliation of Wartime Pharmaceutical Cost Estimates with Earlier Pharmaceutical Cost Figures, England and Wales.

Source	Pharmaceutical Drug Cost	Population Coverage
National Health Insurance Expenditure 1938	£2,412,000	18,883,000
National Health Service (expected cost grossing up 1938 NHI figures)	£5.547.000	41,250,000
Wartime NHS Pharmaceutical Cost Estimates	£5-6 million	41,250,000

Sources: Cmd. 6089; MH 80/31; MH 80/26;

What the Table shows is that, if NHI drug expenditure is grossed up to the population to be covered, this gives an estimated cost figure of roughly £5.5million. This is consistent with the estimates embodied in the Approximate Cost and Finance of New Health Service estimates if rounded down and with the estimate included in the White Paper if rounded up. While such a reconstruction cannot be conclusive it suggests that an extrapolation may have been used in this case. If this was so then it involved two problems.

The first is that expenditure could be higher than a grossed up population figure because of a backlog of health problems relating to lower levels of population coverage under NHI. This, in turn, could trigger an increase in consultation rates and a linked increase in prescriptions per person. A classic example here would relate to women whose NHI coverage, being linked to employment, was much lower. Spring-Rice's classic account (1981, first published 1939) graphically documents the long-term health problems amongst working class women at the end of the inter-war period.

The other major problem with such extrapolations is the assumption that cost per prescription patterns prevailing under a future NHS would replicate those experienced

under NHI. This could not be assumed since the pattern would depend, inter alia, on patterns of development of effective pharmaceutical products and their cost. Thus the (apparent) use of extrapolation was a hostage to fortune with respect to future pharmaceutical costs.

Conclusion

A number of conclusions can be drawn from the research discussed in this Chapter. It suggests that financial control problems varied across the Service. Financial control was generally unproblematic in the General Medical Service because of the operation of the pay pool for GPs. This meant that pay levels were broadly separated from either the form of pay or levels of service demand. This has another important implication. Salary versus capitation was of central importance as an issue of *health policy*. However, it was of very limited importance as an issue of *financial control* since either form could be accommodated within the financial limits of the pool.

Another contribution of the research is the new light which is thrown on the abandonment of health centres. This was discussed at the time and in modern historical research in terms of textual formulations which suggested that the role of health centres was shifting from that of a model to a small scale experiment. What such formulations could not show was any quantitative estimate of this shift in policy. It has been possible to do this by examining the cost estimates and the analysis shows a dramatic change from a universal health centre approach to one covering less than 4 per cent of the population of England and Wales. This conclusion supports the argument, advanced in Chapter 1, that the study of financial data can be a valuable additional source in the historical analysis of health policy.

The broad absence of financial control problems in this area was, however, subject to exceptions. Capitation generated the potential for low pay problems and professional resistance to resolving them by using salary meant that attempts to resolve them involved pressure for higher capitation fees. This, as in the Danckwerts award, resulted in periodic increases in the overall size of the pay pool. A different cost control issue was posed by pharmaceutical costs. Here expenditure was linked to service demand and the estimates were problematic because they appear to have used simplistic extrapolations from NHI experience. This link between expenditure and demand levels leads to a consideration of other areas of the Service where the link was more significant than in the case of the General Medical Service. A marked contrast is provided by the experience of the Dental and Ophthalmic parts of the Service and these are discussed in Chapter 3.

Chapter Three: Paying for Past Omissions: The Dental and Ophthalmic Services 1942-1948.

Introduction

The object of this Chapter is consider issues of expenditure control raised by the Dental and Ophthalmic services. The experience of these services was radically different to that of the General Medical Service discussed Chapter 2. As was pointed out there, although the capitation system generated periodic pressure to increase capitation fees and pharmaceutical costs did pose expenditure control problems the operation of a de facto pay pool meant that GP remuneration was relatively easy to control. Equally, this was reflected in the lack of concern with this area of expenditure in the 'crisis of expenditure' of the first two fiscal years of the Service. In contrast Dental and Ophthalmic services were important in that crisis in two ways: firstly because there were considerable cost over-runs in these areas and they contributed significantly to the overall gap between estimates and expenditure in those years. This was the case even though the two services were expected to be a relatively inexpensive part of the NHS. Details of the role of expenditure over-runs in these areas as contributors to the overall gap between expenditure and estimates in the first two fiscal years of the Service will be analysed in Chapter 5. However, the combination of a significant role in such over-runs with a low initial expected cost meant that the extent of over-runs in these particular services were substantial. Again details are given in Chapter 5 but the size of the gaps between expenditure and estimates in these areas operated to heighten a sense of 'crisis' in that period.

The aim of this Chapter is to consider the roots of these substantial differences between estimates and expenditure. The argument advanced is that three broad determinants were

crucial. The first was that limitations of coverage, during the inter-war period, meant that there was a substantial backlog of unmet needs which could translate into high demand when conditions of universal access, free at the point of use, applied. However, as was pointed out in the Chapter 2, such a situation was not unique to the dental and ophthalmic services. If such latent demand was to result in an expenditure ‘problem’ this presupposed a form of remuneration which linked demand directly to pay. As was demonstrated in Chapter 2, such a link did not apply in the case of GP remuneration because of the pay pool. However, in Dental and Ophthalmic services the link *did* operate since pay was on a fee for service basis. Consequently increased service demand resulted in higher fees and thus higher expenditure.

The third feature relates to the ability of the Ministry to forecast expected demand levels. A central question posed in Chapter 1 was how far cost under-estimates were due to deficiencies in the capacity to produce sound estimates within the Ministry and how far they related to aspects of Service costs which the Ministry could not have been expected to anticipate. In the services examined in this Chapter both features were significant. Thus it will be argued that the effect of policy changes after the 1944 White Paper estimate meant that the direction adopted was distinct from that presupposed in the White Paper and this shift had important expenditure implications. However, it is also possible to find important weaknesses in the approach to estimation taken and these will be outlined.

The Chapter is divided into four sections: the first discusses the basis for the latent demand by examining limitations on coverage in the inter-war period. The second considers the reasons for the adoption of a fee for service mode of payment. The third

section examines how the Dental and Ophthalmic estimates were produced and traces them through the three key estimates discussed in Chapter 2; and the fourth section looks at some of the reasons for difficulties with these estimates. The conclusion draws together the evidence as to why this part of the Service did raise important problems of financial control.

Problems in Inter-War Provision

One source of the cost over-runs in Dental and Ophthalmic services was the backlog of demand stemming from limitations on provision in the inter-war period. To examine such limitations the two major areas of public provision in that period, the School Medical Service and the National Health Insurance (NHI) scheme are examined.

The School Medical Service: Dental Provision

Under the Education (Administrative Provisions) Act of 1907 local authorities were obliged to undertake the inspection of elementary school children (Harris, 1995: 48); and the obligation to provide treatment was introduced in the Education Act 1918 (ibid.: 80). Table 3.1 shows the trends in dental inspection and treatment in England and Wales over the period 1926-1938.

Table 3.1: Dental Inspection and Treatment: School Medical Service: England and Wales 1926-1938.

Year (1)	Average number of pupils on rolls (2)	Total numbers inspected (3)	Total referred for treatment (4)	Numbers treated (5)	Numbers treated as a percentage of numbers referred (5 as % of 4) (6)	Numbers inspected as a % of average number on rolls (3 as a % of 2) (7)
1926	5,631,560	2,213,721	1,478,413	852,517	57.7	39.3
1927	5,635,412	2,394,506	1,610,953	935,773	58.1	42.5
1928	5,611,063	2,646,138	1,785,680	1,042,629	58.4	47.2
1929	5,574,254	2,749,602	1,890,443	1,105,633	58.5	49.3
1930	5,546,002	2,840,270	1,974,856	1,252,552	63.4	51.2
1931	5,538,772	3,071,827	2,117,031	1,335,914	63.1	55.5
1932	5,576,419	3,302,338	2,285,644	1,400,928	61.3	59.2
1933	5,635,216	3,303,983	2,263,135	1,382,819	61.1	58.6
1934	5,649,354	3,303,838	2,273,508	1,431,775	63.0	58.5
1935	5,468,960	3,366,818	2,290,404	1,474,083	64.4	61.6
1936	5,321,065	3,463,948	2,425,299	1,536,627	63.4	65.1
1937	5,185,298	3,503,232	2,469,623	1,544,766	62.6	67.5
1938	5,087,485	3,531,341	2,497,930	1,635,512	65.5	69.4

Sources: Simon (1974), Column 1; Board of Education 1927-1938 Columns 2-6; own calculations, Column 7.

Column one figures for fiscal years, other columns calendar years.

The data in the Table shows an expansion of provision: the numbers of inspections increased 59.5 per cent over the period from 2,213,721 to 3,531,341; numbers treated increased 69 per cent from 1,478,413 to 2,497,930; and the percentage of those referred for treatment who received treatment increased from 57.7 per cent to 65.5 per cent.

However, there were still serious deficiencies. Column 6 in the Table is of particular interest because it was regularly published in the source for inspections, referrals and treatment used in the Table, the Annual Report of the Chief Medical Officer to the Board of Education. It could thus be seen as an official indicator how far need (measured by

referrals) was being met. Even if this indicator is accepted then, at the end of the inter-war period, there was still considerable under-provision since, in 1938, only 65.5 per cent of those referred for treatment were receiving treatment.

However, there were also a number of reasons for regarding this indicator as flawed. As Column 7 in the Table indicates, inspection was far from universal in the period and, although rates improved, by 1938 less than 70 per cent of pupils on the register received dental inspections. This criticism was raised in contemporary social surveys. The Social Survey of Merseyside, published in 1934, showed that the percentages of elementary school children given dental inspections in 1931 was 45 per cent in Liverpool; 79 per cent in Bootle; 45 per cent in Birkenhead and 38 per cent in Wallasey (Caradog Jones, 1934: 39). These figures led to the comment that it was 'remarkable' that '...it has been thought better to provide regular, if infrequent, inspection and treatment for some of the children and to leave the remainder entirely uncared for' (ibid.: 39-40; see also Welshman, 1998: 320).

The validity of the 'percentage treated' measure as an indicator depends upon referrals being a reasonably accurate indicator of the need for dental treatment amongst those children who were inspected. However, as Welshman (1998: 311-312 and 314) points out, standards of school dental inspection came under frequent criticism from dentists as superficial and inadequate throughout the inter-war period. This involved the corollary (ibid.) that the need for treatment was substantially greater than was being registered in official referral figures. An illustration of the potential impact of different levels of rigour of inspection was given by M'Gonigle. He pointed to differences in the percentage of children found free from dental caries in a study he had undertaken and one conducted by

Mellanby (M'Gonigle and Kirby, 1936: 60-1). M'Gonigle's study of 794 5 year olds in Durham found 11 per cent of boys and 16.5 per cent of girls with a set of teeth free from caries (ibid.: 61). In contrast Mellanby's study of 5 year olds in 33 elementary schools found a much lower percentage of children free from caries (4.7 per cent overall) (ibid.: 60, on Mellanby's influence, as a researcher, on dental policy in this period, see Welshman, 1998: 315-9). M'Gonigle pointed out that Mellanby's inspection method was more rigorous than his own since she used a probe and he did not and he concluded that his own study had over-estimated the percentage of children with teeth free from caries (M'Gonigle and Kirby, 1936: 61).

It is also worth noting that the disjuncture between the numbers referred for treatment and receiving it was frequently interpreted in a 'less eligibility' framework. Thus Welshman (1998: 325) points to the Chief Medical Officer in Leicester, a relatively progressive authority from the standpoint of dental provision for children, blaming parents for failing to avail themselves sufficiently of treatment opportunities.

So far the argument has focused on levels of inspection and treatment. However, it is also important to discuss the nature of the treatment provided. A characterisation of dental treatment in the inter-war period was that it was a 'breakdown' service, a term used to describe NHI practice in that period in a report by the British Dental Association published in 1941 (Webster, 1988a: 358). This referred to the emphasis on extractions rather than conservation of teeth because treatment would be sought when teeth were already too decayed to allow for a 'conservative' approach and extraction was used to relieve pain. This might also have been encouraged by relative prices and King (1994: 16) cites an estimate of a 'two surface' filling as costing three times as much as an

extraction. Evidence given by Hindle, a dental practitioner, to the Spens Committee on Remuneration of Dentists (discussed below), also showed fillings as costing on average three times as much as extractions (Hindle, Synopsis of Evidence for Dental Spens Committee, 29th November 1947, PRO, MH 77/167). Table 3.2 shows the dominance of extraction as the principal form of treatment in the School Medical Service. Even though, after 1929, there was a trend to more emphasis on fillings the number of extractions was still more than double the number of fillings at the end of the inter-war period. Thus in terms of the scope of inspection, its rigour, the availability and form of treatment there were serious defects in the School Medical Service.

Table 3.2: Ratio of Extractions to Fillings: School Medical Service: England and Wales, 1926-1938.

Year (1)	Extractions (2)	Fillings (3)	Ratio: Extractions: Fillings (2:3) (4)
1926	1,785,571	579,766	3.1:1
1927	2,004,329	612,995	3.3:1
1928	2,223,836	688,582	3.2:1
1929	2,339,755	716,960	3.3:1
1930	2,638,877	848,638	3.1:1
1931	2,769,933	935,411	3.0:1
1932	2,815,054	999,203	2.8:1
1933	2,618,239	1,018,467	2.6:1
1934	2,695,945	1,059,527	2.5:1
1935	2,818,670	1,128,058	2.5:1
1936	2,987,670	1,250,469	2.4:1
1937	2,911,584	1,293,138	2.3:1
1938	3,086,736	1,397,124	2.2:1

Source: Board of Education Columns 1-3; own calculations, Column 4.

The School Medical Service: Ophthalmic Services

Welshman (1998) has characterised as the study of dental provision under the School Medical Service as a 'neglected area' but this term could apply even more accurately to ophthalmic provision. Harris (1995: 109) has shown that there were increases in the

number of Local Education Authorities giving medical treatment for 'defective vision' and supplying spectacles from 280 in 1920 to 314 in 1938 in the case of the former; and from 282 to 312 in the case of the latter. Figures on the number of inspections were given in the Annual Report of the Chief Medical Officer to the Board of Education. Data for 1926-36 are given in Table 3.3. There are two striking features of the Table. The first is the consistently very low percentage of elementary school children tested for defective vision and squint. The second is that, unlike the upward trend of inspections in the dental part of the School Medical Service noted earlier, both the number of inspections and the percentage of children inspected remained flat over the period (data for 1937 and 1938 is presented in a form which is not consistent with that for 1926-36). The number of inspections fluctuated between 1,100,000 and 1,250,000 and the percentage of children inspected fluctuated in the 20 to 22 per cent range.

Table 3.3. Inspections for Defective Vision and Squint: School Medical Service, England and Wales, 1926-1936.

Year (1)	Average number of pupils on rolls (2)	Number of Inspections (3)	Inspections as a % of Numbers on Rolls (3 as % of 2) (4)
1926	5,631,560	1,125,470	20.0
1927	5,635,412	1,137,450	20.2
1928	5,611,063	1,253,872	22.3
1929	5,574,254	1,199,291	21.5
1930	5,546,002	1,142,672	20.6
1931	5,538,772	1,137,364	20.5
1932	5,576,419	1,245,995	22.3
1933	5,635,216	1,269,352	22.5
1934	5,649,354	1,271,520	21.6
1935	5,468,960	1,149,111	21.0
1936	5,321,065	1,148,891	21.6

Source: Simon (1974), Column 1; Board of Education, Columns 2 and 3; own calculations, Column 4.

Column one figures for fiscal years, other columns calendar years.

In this respect the scope of the ophthalmic service within the School Medical Service appears more restricted than that of the dental service.

National Health Insurance

The second major source of dental and ophthalmic provision in the inter-war period was through National Health Insurance (NHI). However, this was subject to two types of limitations in terms of coverage. Firstly, NHI gave insurance based benefits to individual scheme members not to non-working spouses or children. Naturally this limited cover to the working population and a further limitation applied because of income limits in the scheme (for its scope see Cmd 6404: 223-4). Secondly, dental and ophthalmic services were 'additional' benefits. This meant that, unlike access to the General Practitioner Service, they were not an entitlement of each member. Entitlement depended on the financial situation of the approved society of which the individual was a member. If a society had an actuarial surplus it was, subject to the approval of the Ministry of Health, able to use that surplus on benefits 'additional' to the basic benefits offered by the scheme (National Health Insurance Act 1936, Section 104). Such 'additions' could take two broad forms: 'cash' benefits which meant that the society offered a higher rate of sick pay than the basic rate in the scheme; and 'treatment' benefits which gave access to forms of health care not covered in the basic scheme.

Table 3.4 is drawn from the Fifth Valuation of the assets and liabilities of approved societies, the figures are for the United Kingdom and the valuation was published in 1943. As can be seen from the Table, Dental and Ophthalmic benefits were the most important treatment benefits with both the highest coverage levels and allocations of funding per member. Nevertheless the Table shows that there were important limitations

on coverage: male coverage rates were higher for both benefits and there is a particularly marked gender gap for ophthalmic benefits.

Equally these gender differences have to be set in the context of further inequalities of scheme membership themselves reflecting variations in male and female participation in the labour market during this period. Table 3.5 shows male membership of approved societies at broadly double the level of female both per se and in societies which offered 'additional' benefits.

Table 3.4: Main Treatment Benefits under National Health Insurance, Fifth Valuation of Approved Society Assets and Liabilities, 1943.

Benefit	Men (% covered)	Women (% covered)	Total (% covered)	Average allocation per member
Dental	84	61	76	3/6d (17.5p)
Ophthalmic	84	28	65	1/1d (5p)
Medical/Surgical Appliances	80	26	62	4d (2p)
Convalescent Home	69	39	59	4d (2p)
Hospital Treatment	13	6	10	11d. (5p)

Source: Cmd. 6455.

Table 3.5: Scheme Membership under National Health Insurance, Fifth Valuation of Approved Society Assets and Liabilities, 1943.

	Men	Women	Total
Societies with additional benefits	10,595,000	4,930,000	15,525,000
Total Society Membership	12,057,000	6,111,000	18,168,000

Source: Cmd. 6455.

At the end of the inter-war period state administration and finance of dental and ophthalmic benefits was governed by regulations issued under the National Health Insurance Act 1936. There were a number of similarities in the regulations governing

both benefits. In both cases provision was not necessarily free. The regulations required that approved societies contribute part of the cost of 'optical appliances' in the case of ophthalmic benefit and of treatment and appliance costs in the case of dental benefit. For example, under dental benefit, the society was required to meet half the cost of treatment except where its cost did not exceed 10/- (50p.) where the society was obliged to meet the full cost (Statutory Rules and Orders, 1938, Vol. II, Order 1466, para. 19).

Where a member was covered they would apply to the society which would issue a form which was termed either a 'dental' or an 'ophthalmic' letter according to whichever benefit was involved. (ibid. para. 22 (1); Statutory Rules and Orders, 1937, No. 973), para. 8 (a). Generally the member would take the 'letter' to the dental or ophthalmic practitioner and an estimate would be prepared. This had to be approved by the society and then treatment could commence. Once treatment was completed the 'letter' was returned signed by the practitioner and the member. Payment operated via a fee for service basis and the regulations laid down a standard fee structure (e.g. for the dental service, see Statutory Rules and Orders, 1938, no. 1466, Second Schedule).

Thus, as with the School Medical Service, there were significant limits on coverage. Cover of any kind depended on participation in the labour market. Even then access to dental and ophthalmic benefits relied on the member's society having an actuarial surplus; and the member was generally expected to meet some of the costs of provision. These limitations created the conditions for unmet needs. However this would not necessarily trigger expenditure since for this to happen what was needed was a remuneration structure which directly linked demand to expenditure. This did operate in the Dental and Ophthalmic services since a fee for service structure applied there and, in

the next section, the aim is to account for why this system of payment applied in these services.

Translating Demand into Expenditure: Fee for Service

Dentistry

In the case of dentistry there are certain parallels between the debates on forms of pay for GPs discussed in Chapter 2. As was indicated in the last section, under NHI payment for dental services was on a fee for service basis which was also the usual form of payment in private dental practice. However, in documents prepared in the context of wartime health planning there is evidence of a distrust of this form of payment and a sympathy with the use of salary. As was indicated in the Chapter 2, capitation was seen, within the Ministry, as potentially inimical of professional standards in general practice. Similar criticisms were raised with respect to fee for service under NHI which was said to promote ‘the salesmanship aspect of dentistry rather than the professional outlook’ (No author, *Dentistry in a National Health Service*, 1944, undated, with papers of April 1944, PRO, MH 77/124). In another paper capitation was considered as a form of payment but rejected on the grounds that it would encourage extractions ‘...because very little work is required thereafter’ (Summers, *Dentistry in a National Health Service*, Second Paper, 27th April 1944, PRO, MH 77/124). In addition the paper reiterated the suspicion of fee for service as putting a ‘premium on excessive treatment’ (ibid.). This appeared to point in the possible direction of salary and this was discussed in a later paper but, as with GPs, there was resistance within the profession. The Scottish Committee on Dental Post-War Reconstruction distributed a questionnaire to 2,592 dentists and responses appear to have been given by 2,302 respondents: 1614 (70.7%) favoured the retention of NHI fees; 436

(18.9%) supported capitation; but only 252 (11%) wanted salary (Wilkinson, Dentistry in a National Health Service, Third Paper, 21st June 1944, PRO, MH 77/124).

Hostility to salary was particularly marked in the case of the British Dental Association (BDA). The BDA was strongly attached to market principles and this was reflected on its policy on the preferred form of remuneration for dentists. This was termed 'grant-in-aid' and allowed for a standard charge for a service, fixed by the state, which could be increased by the dentist at their discretion (Interdepartmental Committee on Remuneration of General Dental Practitioners, Minutes of Meetings Held on 17th and 18th December 1947, PRO, MH 77/164). Bevan resisted this approach since it contradicted the principle of free dental treatment in the Service (*ibid.*). However, it was indicative of the extent to which the BDA was antipathetic to 'public service' concepts of dental practice and hence to salary.

In addition salary had been the form of payment in the School Medical Service but this was associated with poor conditions of service for dentists. For example, the dental surgeon to the Torquay County Council Elementary Schools estimated that school dental work was undertaken at less than a third of the equivalent rate to that of private dentistry (Strangeways, 1922: 319-20; see also Welshman 1998: 313).

As in the case of GPs, Sir Will Spens was asked to chair an Inter-Departmental Committee on the remuneration of General Dental Practitioners. This was principally concerned with levels of remuneration rather than the form of pay, but perhaps an indicator of that Committee's acceptance of professional hostility to salary was the *de facto* assumption, in its Report, that payment would be via fee for service. The Committee was formally neutral on the issue of the form of pay but it argued that 'so far

as total remuneration will be determined by payments in respect of particular dental operations' then 'payments for different dental operations should be so balanced that over any considerable period remuneration should not be affected by the proportion of time spent upon dental operations of various types' (Cmd. 7402: para. 19). This, of course, did not *require* that fee for service would be the form of payment adopted but the fact that such a recommendation was made suggests the Committee's expectation that this *would* be the form adopted for the dental service (see also Webster, 1988a: 119). Thus, in the case of dentistry professional resistance to alternatives to fee for service allowed for an effective retention of the NHI payment structure notwithstanding reservations in the Ministry.

Ophthalmic Services

In the case of ophthalmic services the form of pay adopted was linked to a rather different set of issues that of the long running intra professional rivalry between two groups: medically trained ophthalmic practitioners, usually referred to as ophthalmologists ; and sight-testing or ophthalmic opticians who combined the testing of sight for 'errors of refraction' and the prescription of spectacles. The role of ophthalmic opticians was particularly important because, to an even greater extent than GPs, they operated on a small business basis. Thus, as Larkin (1983: 24) argues they '...were commercial craftsmen concerned to maintain and protect their markets'.

A key role for ophthalmic opticians in the NHS meant that a fee for service basis characteristic of the business transactions with which they were familiar and enshrined in NHI practice, would play a central role in the new Service. However, the autonomy of ophthalmic opticians from medical control was certainly not inevitable and there were

significant countervailing forces to it which might have been expected to mean that it was an unlikely outcome. To understand this issue it is necessary to examine the basis of the intra-professional conflict and its effects. The central argument used by medical practitioners in this field was that there were crucial links between eye diseases and general health and thus that ophthalmic opticians, as non-medical practitioners, were not qualified to adequately diagnose eye diseases. The logic of this position was that they should either limit their role to the dispensing of spectacles (Larkin, 1983: 42); or work, effectively, as auxiliaries to ophthalmologists. In contrast ophthalmic opticians laid claim to a knowledge base which was independent of medicine (ibid.: 24). They argued that this knowledge base justified them both in having a role independent of medically qualified practitioners; and that the public should have direct access to their services (ibid.: 40-1).

The case for medically trained practitioners in this area rested on claims of widespread errors in diagnosis by ophthalmic opticians. This, in turn, generated a debate between the two professional groups. This can be illustrated by conflicting evidence given to the Royal Commission on National Health Insurance (1926). Evidence sympathetic to ophthalmic opticians was given by the National Conference of Approved Societies which suggested that only 5 per cent of NHI ophthalmic patients had serious eye conditions (Larkin, 1983: 46); the implication was that the need for specialist medical practitioners in the ophthalmic service was very limited. The background to such sympathetic evidence from this source was that the fees of ophthalmic opticians were substantially lower than ophthalmologists, a feature appealing to approved societies seeking to conserve their funds. In contrast Dr. Alfred Cox of the British Medical Association told the Royal Commission that 50 per cent of NHI patients had such serious eye conditions

(ibid.). Clearly this led to the converse conclusion that ophthalmologists should have a central role in any ophthalmic service. Such disputes continued throughout the inter-war years into the period of wartime health planning.

The claim that sight-testing opticians were not able to adequately diagnose eye diseases was reiterated in research results published in the *British Medical Journal* (Herman, 1939). This article considered evidence taken from a sample of cases referred to the National Ophthalmic Treatment Board (NOTB) which was set up to allow collaboration between ophthalmologists and opticians, who limited themselves to dispensing with the aim of narrowing the gaps in fees charged for services provided by ophthalmologists and ophthalmic opticians (Political and Economic Planning, 1937: 188). It was argued that, whereas 35.58 per cent of a sample of cases referred to the NOTB revealed serious problems of eye disease (Herman, 1939: 65) the rate of diagnosis of such conditions under NHI, where diagnosis was principally by sight-testing opticians was only 3 per cent. Again the implication was that this was an index of the lack of diagnostic competence on the part of sight-testing opticians.

These contentions were disputed by opticians. A report by a committee of opticians' organisations argued that such comparisons were spurious because the two groups were not comparable. Cases referred to the NOTB would, it was argued, be through GPs who already suspected a serious eye condition; by self-referral by individuals who again had a concern that they might have such a condition; or through an emergency or injury. Thus it should be expected that a sample of such cases would reveal a larger proportion of serious conditions than would be characteristic of the rate for the NHI population

(Beveridge Report (Ad Hoc) Committee (Optical Profession), *The Place of the Optical Profession in the Health Services of the Nation*, January 1944, PRO, MH 80/35).

In this inter-professional dispute public policy had favoured the medical practitioners. Thus Larkin (1983: 41) has pointed to the consistent support given to medically qualified practitioners in the field by the Ministry of Health. This, in turn, had a crucial influence on key policy discussions. As was pointed out above, the medical and optician lobbies gave radically contradictory evidence to the Royal Commission on National Health Insurance. The Majority Report of the Royal Commission, while it expressed concern over the difficulties of adjudicating between these competing claims, was guided by the 'pro doctor' approach of the Ministry. Thus the Majority Report argued with respect to the conflicting evidence submitted on diagnosis 'we feel that this is a very contentious matter on which it is difficult for laymen to pass judgement' (Cmd. 2596: para. 48). However, it went on to state 'but we understand that the Ministry of Health, acting on the advice of medical advisors, have taken the view that the medical practitioner must intervene and in this conclusion we think we must concur' (ibid.). Larkin (1983:41) argues that Ministry support for the doctors reflected the inter-professional balance of power under NHI. Doctors were central to NHI because they were providing a benefit provided to all members; whereas opticians were merely providing an 'additional' benefit. Such Ministry support for the medical case was a consistent policy stance.

In 1927 the Joint Council of Qualified Opticians had sponsored a bill aimed at obtaining state registration for its members. This led to the establishment of a departmental committee to consider the issue (Political and Economic Planning, 1937: 187). The Majority report of the Committee took the view that the ideal form of treatment was by

an ophthalmologist since the latter would combine both a skill in sight testing with the ability to diagnose and treat eye diseases (Cmd. 2999: para. 25). It accepted the argument that some opticians were also able to combine these skills but claimed that this only applied to a section of the profession (ibid.: para. 33). The acceptance of the argument that medically qualified practitioners provided a superior service was used to reject the policy of a register of opticians since this was seen as encouraging public acceptance of an inferior form of treatment.

During wartime planning the long-term desirability of ophthalmic treatment under the authority of an ophthalmologist was reasserted (see for example, Hickinbotham, National Health Service: Dental and Ophthalmic Benefit, 30th April 1943, PRO MH 80/35). Similarly, the preferred form of provision outline in the NHS Bill asserted ‘the object is to secure that the care of the eyes is carried out as rapidly as resources allow – in special ophthalmic departments and clinics forming part of the hospital and specialist service. Those clinics will be in the charge of specialist medical ophthalmologists and in them qualified sight-testing opticians will...play their proper professional part...’ (Cmd. 6761: para. 65). While pay arrangements were not specified in this statement the implication was salary since this was the form of pay operating generally within the hospital service. Equally this might be expected to apply to opticians operating in a de facto auxiliary role to ophthalmologists who would have ‘charge’ of the clinic. This policy direction which, as has been indicated consistent with the trend of Ministry of Health policy appeared to carry the implication that fee for service forms of payment might have no place in the ophthalmic service and this, in turn, would have broken the direct link between service usage and expenditure.

However, this did not happen and the key to why opticians remained dominant providers and fee for service the central form of remuneration can be discerned from a crucial caveat in the NHS Bill. The long run policy of clinic provision within the hospital service was to apply 'as rapidly as resources allow' (Cmd. 6761: para. 65). The underlying problem with the preferred approach was that it was constrained by the imbalance in the supply of opticians on one hand and ophthalmologists on the other. Thus Larkin (1983: 40) cites a figure of 3,500 opticians in the three Joint Council organisations as against 700 ophthalmologists as recognised by the BMA in the mid 1920s. The Majority Report of the Departmental Committee on Optical Practitioners in 1927 was aware of this imbalance and this led it to qualify its rejection of the register which had been sought by the ophthalmic opticians' organisations. The rejection of the register was based on the expectation that the supply of ophthalmologists would make a medically based service much more accessible. However, it noted: '...if for any reason these hopes are not fulfilled within a reasonable time we do not wish our Report to preclude the possibility of a reconsideration of the question...' (Cmd. 2999: para. 48).

As was pointed out above, in wartime planning, the Ministry continued the policy of supporting a service in which medical supervision was central. However, again the huge imbalance in supply between ophthalmologists and ophthalmic opticians operated as a constraint. A policy document of April 1943 suggested that there were 5,500 ophthalmic opticians were in practice (the text is not entirely clear but the reference appears to be that the figure refers to Great Britain) (Hickinbotham, National Health Service: Dental and Ophthalmic Provision, 30th April 1943, PRO MH 80/35). This contrasted with 939 'medical practitioners engaged in the practice of ophthalmology' (ibid.). This latter

estimate (clearly for the Great Britain) included a broad regional breakdown which showed a further problem of huge regional inequalities. Thus, for example, 247 such practitioners were working in London as against only 23 in Wales (ibid.).

The result of this resource constraint meant that, while a medically run ophthalmic service remained the ideal, ophthalmic opticians were said to be providing a 'valuable service' (ibid.) and the possibility was raised of an opticians list and prohibition of the sale of spectacles by opticians not on an approved list (ibid.) which was tantamount to the registration which opticians had sought in the 1927 Bill.

Finally, as was indicated above, the NHS Bill itself continued the policy of favouring a medically run service but subject to available resources and para. 66 of the Bill (Cmd. 6761) envisaged a 'supplementary' ophthalmic service effectively dominated by provision by ophthalmic opticians (see Webster, 1988a: 370 for figures on numbers of ophthalmologists and ophthalmic opticians in 1949). Thus the persistent imbalance between the supply of practitioners from the rival professional groups meant that opticians as 'commercial craftsmen' (Larkin, 1983: 24) retained a central role and, as with dentistry, NHI fee for service remuneration structures were carried into the NHS. In both cases a form of remuneration was adopted which would involve a direct link between service demand and expenditure. This meant that the accuracy of cost estimates depended critically on how far demand levels could be accurately forecast. These issues are examined in the final two sections of the Chapter.

The Dental and Ophthalmic Estimates

Ideals and Constraints: the Priority Group Policy

In this section the aim is to discuss how the key dental and ophthalmic estimates were derived. However, before looking at this issue directly it is necessary to consider an important contextual question. This is the tension between seeking to provide a comprehensive service and, in the light of resource constraints, the argument that, initially at least, services should only be available to ‘priority groups’. This issue was particularly significant in policy debates on the dental service.

Welshman (1998: 322) has argued that there was evidence of a ‘sea change’ in attitudes towards dental services during the Second World War. As was indicated above, an important element in inter-war thinking was that low levels of take-up in the School Medical Service were a function of parental ignorance or negligence. In contrast the ‘sea change’ led to a tendency to see low take-up as rooted in structural problems such as poverty (ibid.) and hence it was increasingly seen as an issue of public policy rather than purely one of individual responsibility.

In addition to the limits on coverage in the School Medical Service, discussed earlier, under NHI, it was estimated that of those covered for dental benefit only 6-7 per cent claimed it per year (Report of a Committee on Post-War Dental Policy, 11th February 1943, PRO, MH 80/35). In wartime this general low level of take-up was seen as a policy problem which meant that, by the time treatment was sought, irreversible damage to teeth had already occurred. A good summary of this view is contained in the Report of the [Inter-Departmental] Committee on Post-War Dental Policy, a Committee of civil servants chaired by the Permanent Secretary, Sir John Maude. The Report stated: ‘The

demand for the services available is very low and in a high percentage of cases where treatment is sought the dental condition is such that the only treatment possible is wholesale extraction and the provision of dentures (ibid.)

The lack of effective preventative work in this area was reflected in data, from various sources, both on the nature of dental work undertaken and on the state of dental health at the end of the inter-war period and during the Second World War. Table 3.6 shows evidence of patterns of treatment from two sources: from a maternity and child welfare clinic in Cambridge treating mothers and children; and from an analysis of patterns of treatment based on data from 10,000 'dental letters'. Both are indicative of the strong bias towards extractions and away from 'conservative' forms of treatment such as fillings and parallel the data presented earlier relating to the dental provision under the School Medical Service.

Table 3.6: Pattern of Dental Treatment at the End of the Inter-War Period and During the Second World War.

Source	Extractions (1) (numbers)	Fillings (2) (numbers)	Extractions/Fillings Ratio (1:2)
Cambridge Maternity/Child Welfare 1937	827	107	7.7
Cambridge Maternity/Child Welfare 1941	924	199	4.6
Analysis of 'Dental Letters' 1935	78,920	12,817	6.2

Source: Committee on Post-War Dental Policy, Dental Services, 29th November 1942, PRO, MH 77/183 and own calculations.

Table 3.7 is drawn from a survey of three Royal Ordnance factories (Bridgend, Chorley and Swynnerton), the survey is not dated but the results appear in a document of the Committee on Post-War Dental Policy dated 29/10/42 (PRO, MH 77/183). The impact of a lack of effective preventative work is illustrated by the large proportion of the workforce with either partial or full dentures.

In the light of the policy 'sea change' the evidence of the failure to prevent tooth decay was taken as indicative of the need not just to improve service coverage but also the utilisation of services, particularly as a means of preventative policy. However, this ideal policy was seen, by the Committee on Post-War Dental Policy, as constrained by the supply of dentists. The Committee stated that 12,000 registered dentists were in practice and that while 'this is adequate to present effective demand for dental treatment' it was 'inadequate to secure any substantial improvement in the dental condition of the nation' (Report of a Committee on Post-War Dental Policy, 11th February, 1943, PRO, MH 80/35). In part the problem of shortage of dentists was related to the age structure of the profession. A later analysis by the Government Actuary showed that while there were

14,459 dentists on the dental register at 31st December 1942 12,960 were under 65 and of this group 1,259 were over 60 (Cmd. 6565: 25).

The Committee claimed, although there is no evidence in the documents for how this figure was generated, that ‘...if every person in the country were to demand and receive the treatment [their] condition required’ then 60,000 practising dentists would be needed’ (Report of a Committee on Post-War Dental Policy, 11th February, 1943, MH 80/35).

This substantial postulated disjuncture between ideal levels of supply of dentists and current numbers in practice led the Committee to favour a policy of concentration of resources on ‘priority’ groups. The report stated that the ‘priority’ groups should consist of nursing and expectant mothers (4 million); school children (7 million) and adolescents 15-17 (2 million) (ibid.). The Inter-Departmental committee’s policy had the corollary that the ideal of stimulating demand for long-term preventative purposes would strictly apply to the priority groups. With respect to the rest of the population it argued: ‘stimulation of demand by education methods, by the provision of clinics and by the extension to the general population of “dental benefit” or its equivalent must be timed to keep pace with the actual increase in the supply of dentists’ (ibid.).

Table 3.7: State of Dental Health: Evidence from a Survey of Royal Ordnance Factories

Group	Numbers	Average Age	Some Dentures (percentage)	Upper and Lower Dentures (percentage)
Single Women				
Bridgend	214	22.6	9	2
Chorley	341	24.6	18	7
Swynnerton	171	27.0	30	16
Married Women				
Bridgend	119	32.8	29	5
Chorley	269	41.4	65	39
Swynnerton	100	35.4	48	36
Men				
Bridgend	42	46.3	43	29
Chorley	363	44.8	57	42
Swynnerton	58	43.5	45	31

Source: Committee on Post-War Dental Services, Dental Service, 29th November 1942, PRO, MH 77/183

There are some inconsistencies between this avowed policy of the Committee and its figures on distribution of dentists between the ‘priority’ groups and the rest of the population. Thus 3,500 dentists would be allocated to cater for the 13 million ‘priority’ population giving a population to dentist ratio of 3714:1. Yet the Committee’s report assumed a post-war dentist supply of 13,500 thus leaving 10,000 dentists to cater for the rest of the population (33,000,000). This, ironically, generated a better dentist to population ratio of 3300:1. Nevertheless, as will be demonstrated below, the support for a ‘priority group’ policy with respect to dental policy had an important influence on the estimates of dental and ophthalmic costs included in the 1944 White Paper. However, before the examining the impact of this policy on that estimate it is necessary to look at

how the Dental and Ophthalmic estimates were derived and, in this analysis, the three key estimates identified in Chapter 2 will be used.

The Cost Estimates

The Dental Estimates

In the Approximate Cost estimate a figure of £30 million is given for the total cost of a dental service under a future NHS and £20 million as the cost to ‘public funds’. The most detailed basis for these figures is given in a slightly earlier document, *Cost of Dental Treatment* of 21st July 1942 (PRO, MH 80/24). The estimate in this document was for just two groups of the population 15-65 (22,500,000) and over 65 (4,300,000). No calculation was given for the 0-15 group (9,500,000). Table 3.8 gives, in a slightly adapted form, the cost figures given in this document.

Table 3.8: Dental Cost Estimates (£) as Given in the ‘Cost of Dental Treatment’ Document, July 1942

15-65				
	Demand	10%	Demand	20%
	Total	Public Funds	Total	Public Funds
Operations	4,000,000	4,000,000	8,000,000	8,000,000
Prosthetic	9,900,000	4,950,000	19,800,000	9,900,000
Total	13,900,000	8,950,000	27,800,000	17,900,000
Over-65				
Operations	175,000	175,000	350,000	350,000
Prosthetic	1,800,000	900,000	3,600,000	1,800,000
Total	1,975,000	1,075,000	3,950,000	2,150,000

Source: Cost of Dental Treatment, 21st July 1942, PRO, MH 80/24

As can be seen from the Table, two demand scenarios are given, one with a ten per cent, the other with a twenty per cent take-up rate. While this is not made explicit it would appear that the calculation presupposes a continuation of the NHI form of remuneration of fee for service. This can be seen from Table 3.9 below which, for illustrative purposes takes the 20 per cent take up assumption. Column 3 in the table gives the average cost per case under NHI at the end of the inter-war period which was £4 5s 4d (£4.27p). Columns 1 and 2 give the population covered and the numbers of cases assuming a 20 per cent per annum take up rate. Column 4 gives an expected cost figure multiplying the number of cases under this scenario with the NHI average cost per case and this, as can be seen from column 5 gives a very close fit with the cost figures given in the *Cost of Dental*

Treatment document

Table 3.9 Comparison of the Cost Estimate Using a Twenty Per Cent Take-Up Assumption in the Costs of Dental Treatment Estimate with an Expected Cost Figure Using NHI average cost per case under Dental Benefit.

(1) Population Covered (15+)	(2) Cases Per Year (20 per cent take-up)	(3) NHI Cost Per Case	(4) Expected Cost (3 X 2)	(5) Cost of Dental Treatment Estimate
36,800,000	7,560,000	£4.27p.	31,400,000	31,750,000

Source: Own calculations and data from Cost of Dental Treatment, 21st July 1942, PRO, MH 80/24

The cost to public funds is reduced in both demand scenarios on the assumption that, whereas treatment would be free, dentures (prosthetic) would involve a charge. The 50 per cent ‘appliance’ charge reflected a general assumption that this was the share of the cost of ‘appliances’ expected to be paid by patients under NHI (see for example Cmd. 6565: para. 52). Given that the Approximate Cost document gives the £30 million (total)

and £20 million (cost to public funds) then it would seem likely that these are rounded versions of the costs based on the 20 per cent demand scenario.

A major shift in the estimate comes in the Finance of New Health Scheme estimate, in this document the cost to public funds is halved to £10 millions (PRO, MH 80/26) and this is also the figure which appears in the 1944 White Paper (Cmd. 6502: 82). The sharp reduction in the estimate is not explained in the Finance of New Health Scheme estimate but it is most reasonably accounted for by the support at this point for the priority group policy espoused by the Inter-Departmental Committee on Post-War Dental Policy referred to above. Thus, for example, a Memorandum to the War Cabinet of 2nd February 1943, by the Minister of Health and the Secretary of State for Scotland included the argument that ‘we have little doubt that...the proper course is to concentrate our efforts on the teeth of the rising generation, and for that purpose to amplify and improve existing services dealing with mothers and pre-school children and to extend that service to adolescents’ (PRO, MH 80/25). This not only endorsed the priority group policy but was seen as having implications for costs. Thus the shift from a comprehensive service was said to mean that estimates can be ‘...substantially cut for the time being’ (ibid.).

Ophthalmic Estimates

There is considerably less detail on the ophthalmic cost estimates but there are certain similarities with the apparent basis for the figures in the Cost of Dental Treatment document. The calculation given in a document on Ophthalmic Benefit of 21st July 1942 (PRO, MH 80/35) is illustrated in Table 3.10 which shows that what was done was to take current NHI cost per case and assume a fifty per contribution to treatment/appliance costs by the user to generate the service cost estimate.

Table 3.10: Cost Estimate for Ophthalmic Benefit, July 1942

(1) NHI Population Coverage	(2) NHI Cost (Public Funds)	(3) NHI Cost Per Head (Public Funds)	(4) NHI Total Cost* Per Head	(5) Future Population Coverage*	(6) Expected Public Cost (3 X 5)	(7) Expected Total Cost (4 X 5)
11.8 million	£630,000	0.5p.	0.10p.	46 million	£2.3 million	£4.6 million

* the total cost per head assumes that half of total cost is paid by the user and the future population figure is the total population of Great Britain at the end of the inter-war period.

Source: Ophthalmic Benefit, 21st July 1942, PRO, MH 80/35

There is a clear link between these estimates and those given in the general cost estimates. Thus the Approximate Cost estimate gives £4 million total costs and £2 million, cost to public funds for a post-war ophthalmic service. As with dental costs there was also a sharp downward revision, thus the Finance of New Health Scheme estimate also reduced the figure by half, giving a cost to public funds of £1 million (Finance of New Health Scheme, 29th September 1943, PRO, MH 80/26). Ophthalmic services are not referred to directly in the February 1943 memorandum from the Minister of Health and the Secretary of State for Scotland, referred to above. However, Johnston, the Secretary of State for Scotland, in winding up the debate on the White Paper, suggested a gradual transition to a comprehensive service stating that ‘we propose that there shall be an ophthalmic service as soon as the required increase of people in the profession can be obtained’ (cited in Hickinbotham, The Ophthalmic Service, 3rd April 1944, PRO, MH 80/35). This approach was carried into the 1944 White Paper, which also cited the £1 million estimate and this suggests a decision to offer a restricted ophthalmic as well as a restricted dental service. The White Paper stated ‘it will take some time to establish the new dental and ophthalmic services and it will probably be several years before the net

expenditure on the services reaches £10m on the former and £1m on the latter (Cmd. 6502: 82).

The Adequacy of the Dental and Ophthalmic Estimates

In this final section the aim is to discuss the adequacy of the approach to estimation adopted in the Ministry. This discussion relates to two general issues raised in Chapter 1: how far inaccuracy in estimates related to determinants within and outside the control of the Ministry; and the statements made in the historical literature regarding how cost estimates were prepared.

With respect to the first question it is important to recognise that wartime estimates were prepared in a context in which certain key policy issues relating to determinants of service demand were in flux. In particular two issues are of major importance: the question of charges; and that of the scope of an immediate post-war Service.

Charges

As was indicated earlier, the assumption of a charge for appliances meant that the cost to public funds of the dental service was reduced by 50 per cent and of the ophthalmic service by 100 per cent. The assumption that charges would be made related to the policy of charging for appliances included in the Beveridge Report where it was argued: 'To ensure careful use, it is reasonable that part of the cost of renewal of dentures should be borne by the person using them...the same holds true of optical appliances' (Cmd. 6404: para. 435). However, a document discussing dental policy pointed to the tension between this position and the policy of divorcing access to the service from ability to pay (Wilkinson, Dentistry in the NHS, Third Paper, 21st June, 1944, MH 77/124). Naturally, such a tension (which would of course also apply to the ophthalmic service) meant that a

policy of charging could reasonably be abandoned on the grounds of acting as a deterrent to service use and raising awkward administrative problems of what did or did not constitute 'misuse' (ibid.). This line of argument suggested the provision of these services free at the point of use. However this had two major expenditure implications. The first was that the totality of service expenditure would fall on public funds. The second, and arguably more important feature, was that the terms of access to the Service would now be radically different from those which applied under NHI since no charge would be made for the user. This meant that demand for the Service could increase because the financial barrier to access was removed.

Towards Universal Provision: The Impact of Teviot

The second source of policy ambivalence was whether a universal service ought to be provided at the outset of the NHS or whether, in the light of resource constraints, a more limited service ought to be offered when the Service started. A precedent for the former was provided by Beveridge since the Report had envisaged 'a comprehensive national health service' which was to include access to 'dental, ophthalmic and surgical appliances' (and thus perhaps by implication dental and ophthalmic treatment) 'for every citizen' (Cmd. 6404: para. 427).

However, as was argued above, the most plausible reconstruction of the sharp downward revision of the dental estimates was the 'priority group' policy. However, this was effectively reversed by the recommendations of the Teviot Committee. This Committee had been appointed in April 1943 and part of its terms of reference were to report on '...the progressive stages by which, having regard to the number of practising dentists, provision for an adequate and satisfactory dental service should be made

available for the population' (Cmd. 6565: para. 1). Such terms virtually implied the presumption of the priority group policy. However, the Interim Report, published in November 1944, recommended that a dental service be provided for the whole population. This was argued on two grounds: it was seen as integral to a comprehensive medical service (ibid.: para. 72) and was necessary to stimulate an awareness of the importance of dental health amongst the population (ibid.: para. 70). Naturally the latter concern was in line with the idea that dental services were being under-utilised and it was noted earlier that the priority group policy went along with downplaying the stimulation of demand for the non-priority group. However, such a reversal would have a clear financial corollary, if a priority group policy was the basis for the White Paper cost estimate figures then the abandonment of such a policy would make these estimates untenable since a universal not a restricted basis of access was now presupposed.

Weaknesses in Estimation?

This policy flux meant that estimates were framed under policy assumptions of a more restricted service involving charges which were later abandoned thus creating conditions for a much higher level of demand. However, it is also possible to point to questionable approaches used by the Ministry in cost estimation.

An interesting issue in the approaches to estimation in the two services relates to the inconsistency in the approaches to estimation of levels of demand. As was indicated above, the fullest discussion in the Cost of Dental Treatment document (MH 80/24), assumes a take-up rate of 20 per cent amongst those covered. This was roughly three times the NHI rate which, as was shown earlier, was estimated at 6-7 per cent. This has important implications for some arguments as to how estimates were prepared in the

Ministry. As was pointed out in Chapter 1, Campbell (1987) and Klein (1995) have suggested that estimates were extrapolated from pre-war expenditure. As was pointed out in the Chapter 2 this is a plausible account of the pharmaceutical cost estimates.

However, the dental estimates show that it is inaccurate as a generalisation since the dental estimates projected much higher levels of demand than those applying under NHI.

No analysis is given as to why the two demand scenarios were chosen nor why, in effect, the 20 per cent rate was selected. However, there could be two different reasons to expect an increase in demand. The first was the policy of seeking to stimulate demand as part of a preventative policy stressing 'conservative' forms of treatment. The other was that there would also be a substantial demand for new dentures. This indeed is implicit in the overall cost figures where the costs of 'prosthetic' treatment account for 71 per cent of the projected total expenditure. Such a backlog could be related to treatment costs in the inter-war period. Thus, for example, King has argued that full dentures cost as much as 10 guineas and this meant that '...many people either did not bother ...or continued to use a set which had become a poor fit' (King, 1994:16; see also Interdepartmental Committee on Remuneration of General Dental Practitioners, Minutes of Meetings Held on 17th and 18th December 1947, PRO, MH 77/164) for evidence from dental practitioners giving similar figures). Of course, it is the case that the estimates assumed a charge for dentures but even extending NHI charges would have meant a much lower cost for dentures. Thus the Second Schedule of the Dental Benefit Regulations stipulated a maximum charge by a dentist of £5 10/ (£5.50p) for upper and lower dentures, a 50 per cent charge would cut this to £2.15s (£2.75p).

However, while there were plausible reasons for planning for a demand increase for dental services, in the case of ophthalmic treatment quite different forecasting criteria were used. As was indicated above, in this case the estimate simply took NHI expenditure levels (and hence, by implication, demand levels) at the end of the inter-war period and extrapolated them to the whole population. Naturally this assumed that NHI take-up levels would remain constant, the increase of cases would merely be an effect of the total population coverage. This assumption may have been made because conditions of access similar to those prevailing under NHI were assumed. Thus, for example, a paper of April 1943 assumed a 50 per cent 'appliance cost' for spectacles (Hickinbotham, National Health Service, Dental and Ophthalmic Provision, 30th April 1943, PRO, MH 80/35) which was generally assumed (see below) to be the usual patient contribution under NHI. However, charges were also assumed in the dental estimates yet with a demand scenario treble that of NHI was assumed. Equally, there was also a basis for expecting a backlog effect similar to that in the dental service.

For example, there was a parallel to the ill-fitting dentures which were tolerated because of the cost of the alternative. A large proportion of the market for spectacles was not via the recommendation of ophthalmologist or sight-testing optician but through what the Majority Report of the Committee on Optical Practitioners Registration Bill called '...cheap spectacles which are sold to people without any attempt being made to test their sight beyond the mere trial of a number of spectacles by the purchaser himself' (Cmd. 2999: para. 15). The same report estimated that retail sales on this basis (at 6d (2.5p) per pair) accounted for 1 million sales annually (ibid.; see also Webster, 1988a: 368).

Again, even with charges it might have been realistic to plan for an increase in demand stemming from the abandonment of inferior spectacles. Naturally, if this were the case, assuming a constant NHI level of service take-up grossed up to a larger population could be substantially inaccurate.

Conclusion

The Dental and Ophthalmic services posed much more difficult problems of cost control than those which, broadly, applied in the General Medical Service. Limitations on coverage created a backlog of demand particularly if universal conditions of access with the removal of financial barriers were to apply. In addition, in both services, fee for service forms of payment meant that there was a direct link between demand and expenditure. Estimation was rendered more difficult because key issues such as whether the Service would be provided on a universal or restricted basis and whether charges would apply were unresolved when estimates were made. However, there were also limitations in the Ministry's approach: there appears to have been little logical basis to the radically different take-up assumptions applied to the dental and ophthalmic services.

The Chapter thus illustrates the diversity of financial control problems in the Service. The documentary research demonstrates the difficulty of generalisations on how cost estimates were prepared. As in the case of pharmaceuticals, the ophthalmic estimates did project NHI experience. However this was not a universal practice as the dental estimates assumed a much higher take-up rate than that which had applied under NHI. The Dental and Ophthalmic services were expected to be relatively inexpensive parts of a future NHS. In contrast, Chapter 4 examines the cost estimates for what was anticipated to be the most expensive part of a future NHS, hospitals.

Chapter Four: The View from a Distance: Hospital Cost Estimates 1942-1944.

Introduction

The importance of hospitals to the NHS has often been signalled by characterising the Service as a national hospital service. This reflects the share of NHS resources devoted to hospitals which has never taken less than half of current expenditure since 1948/9 (Webster, 1996: 808). In this Chapter the aim is to analyse the cost estimates for hospitals in the new Service and their viability. The principal estimates taken are the three used to discuss the General Medical Service in Chapter 2; and the Dental and Ophthalmic services in Chapter 3. The thesis advanced is that, even though the estimate for hospital expenditure was substantially increased between the Approximate Cost figure and that embodied in the 1944 White Paper, all these figures involved a substantial under-estimation of likely costs. This conclusion is reached in the light of consideration of an important contemporary critique of the White Paper estimates (by Robb-Smith, 1944) and of data on hospital costs which were available at the time. It is argued that the failure to use this data was rooted in a 'distant' relationship between the Ministry and the bodies which, in wartime planning, were expected to deliver hospital services, local authorities and voluntary hospitals. This meant that the Ministry did not see its role as exerting financial control over an operating hospital system but rather giving financial support to the bodies which were responsible for hospital provision. This failure in the estimates was particularly serious because of the financial importance of hospitals referred to above and thus it was an important contributory factor in the creation of an atmosphere of crisis which is discussed in more detail in the Chapter 5.

The Chapter is divided into five sections. The first provides a background to the estimates by analysing the nature of hospital provision during the inter-war period. The second section reconstructs the three hospital cost estimates; and the third considers Robb-Smith's critique of the 1944 White Paper estimates. It concludes that this critique, which suggested that the White Paper seriously underestimated hospital costs, was supported by data on hospital costs available at the time. The fourth section examines the political basis for the Ministry's under-estimate setting it in the context of the 'distant' relationship to hospital provision. The fifth and final section considers Ministry responses to Robb-Smith's critique which were triggered by a letter which he wrote to the Minister of Health, Willink, in 1944, and in which he detailed his concerns over the political consequences of the under-estimate. This argument in this section concludes that the Ministry response involved a hostage to fortune since it presupposed a tolerance of cost under-estimates in the Service which might well not be forthcoming. A conclusion draws together the evidence on the Ministry under-estimation of future hospital costs.

Hospital Provision: the Competing Sectors

Hospital provision at the end of the inter-war period was divided between municipal and voluntary sectors. Tables 4.1 and 4.2 show bed numbers and the distribution of beds between hospital categories in England and Wales in 1921 and 1938.

As the Tables indicate, there were a number of striking contrasts between the sectors. In 1938 over two thirds of beds in the voluntary sector were in teaching or general hospitals with just over 3 per cent in the infectious disease or 'chronic and unclassified' categories. In contrast only just over 30 per cent of municipal beds were in 'general' hospitals and this is probably over-stated since public general hospitals also included beds for chronic

cases (Pinker, 1966: 61). Over twenty per cent of beds were in infectious disease

hospitals and a further thirty per cent in the 'chronic/unclassified' category.

Table 4.1 Bed Numbers and Distribution of Beds for the Physically Ill in Voluntary Hospitals (England and Wales) 1921 and 1938.

Hospital Type	1921 Bed Numbers	1938 Bed Numbers	1921 Percentage of Beds	1938 Percentage of Beds
Teaching	9,584	12,610	16.95	14.45
General	27,443	45,397	48.53	52.05
Infectious Disease	178	195	0.31	0.22
Tuberculosis	7,015	7,848	12.40	9.01
Maternity	462	3,587	0.82	4.12
Other Special	9,521	15,114	16.84	17.35
Chronic/Unclassified	2,347	2,484	4.15	2.85
Total	56,550	87,235	100	100

Source: Pinker (1966)

Table 4.2 Bed Numbers and Distribution of Beds for the Physically Ill in Public Hospitals (England and Wales) 1921 and 1938.

Hospital Type	Bed Numbers 1921	Bed Numbers 1938	Percentage of Beds 1921	Percentage of Beds 1938
General	37,840	52,974	22.0	30.1
Infectious Disease	41,415	39,256	24.1	22.3
Tuberculosis	6,531	15,609	3.8	8.9
Maternity	2,463	6,442	1.4	3.7
Other Special	26	5,572		3.1
Chronic/Unclassified	83,731	56,015	48.7	31.8
Total	172,006	175,868	100	100

Source: Pinker (1966)

These contrasts reflected long established differences. In the voluntary hospitals admission policy was set at the level of the individual hospital and, broadly, involved no right to admission (Stone, 1939: 125). In contrast public hospitals operated with duties to

provide beds for patients with infectious diseases, tuberculosis or under the Poor Law (Political and Economic Planning, 1937).

A central influence on how voluntary sector discretion over admission was exercised related to the role of the medical profession in voluntary hospitals. A classic feature of consultant practice in such hospitals was that appointments were honorary. The quid pro quo was that the prestige of appointments (at least to the teaching and larger voluntary hospitals) was a means of attracting private patients and the teaching function encouraged referrals from ex-pupils (Political and Economic Planning, 1937: 240). This pattern was also consistent with the philanthropic purpose of caring for the sick poor (although see Dingwall et al, 1988:2, for caveats on how far, even in the Nineteenth Century, the voluntary hospital patient population was destitute).

As will be indicated below, this philanthropic rationale came under pressure in the context of shifts in the pattern of voluntary hospital financing in the inter-war period. Nevertheless there is considerable evidence of the persistence of the honorary system. Thus, on the eve of the beginning of the NHS, in February 1948, a survey of voluntary hospitals in Greater London showed that two thirds retained the honorary system, 26 per cent made payments and 8 per cent were still deciding their policy on this issue (Unsigned, 1948: 265; Honigsbaum, 1989: 114 and 244).

This unpaid position went along with medical autonomy as its corollary and this, in turn, was reflected in admissions policy. During the Nineteenth Century as hospitals became increasingly significant as vehicles for teaching hospital doctors became resistant to the admission of chronically sick patients (Abel-Smith, 1964: 360). This meant there was a tension between such medical interests and the subscriber's letter system in which

subscribers of hospital funds were given a de facto right to nominate patients (Abel-Smith, 1964: 35; Dingwall et al, 1988: 2-3). However, the emphasis on acute patients was also strengthened by the fact that the expanding volume of in-patient treatment served as an aid to fund raising via appeals (Abel-Smith, 1964: 39).

The assertion of medical control can be seen, for example, in Pinker's figures on average length of patient stay in voluntary hospitals which show sharp reductions between 1861 and 1891 in both London and provincial teaching hospitals (Pinker, 1966: 122). Evidence of medical control over admissions was presented in Bristowe and Holmes's discussion of London hospitals in a report, published in 1864. This pointed to a common policy of excluding infectious disease patients: thus the London, University College, Charing Cross and the Royal Free were reported to refuse admission to any fever case (Bristowe and Holmes, 1864: 38).

This de facto division of labour reflected normative views of medical and non-medical figures in voluntary hospitals. For example, in his evidence to the Royal Commission on the Poor Laws and Relief of Distress, Dr. Lauriston Shaw, physician at Guy's Hospital and, inter alia, Chair of the Marylebone Division of the British Medical Association, argued 'if the illness requires only a moderate amount of nursing skill and attendance it should be treated in the [Poor Law] infirmary. If it requires the medical aid of a specialist for its treatment, if it requires the constant attendance of dressers or if its observation is likely to lead to important additions to medical knowledge it should be treated in a voluntary hospital' (Cd. 4755: Sixty Seventh Day, Qu. 33118; see also Crowther, 1981: 180-1).

Shaw's remarks reflect a clear sense of not just a division of function but one of medical status, since the pursuit of 'additions to medical knowledge' were to be concentrated in voluntary hospitals. This division was also one of social hierarchy since most public provision in the Edwardian period was under the Poor Law. Pinker's figures on public provision in 1911 show that there were 16,301 beds in local authority non poor law hospitals in that year, 15,126 of them infectious disease provision, as against 100,441 in Poor Law institutions (Pinker, 1966: 105 and 107). The Poor Law medical service was, however, 'tainted' by the principles of less eligibility and the user was a 'pauper' rather than a 'patient' (see Crowther, 1984: 42 and 47).

The Increasing Centrality of the Hospital

However, this division of labour was changing. The Royal Commission on the Poor Laws received a report from Dr. McVail which pointed to the heterogeneity of Poor Law hospital standards in England and Wales. For example, in his discussion of urban unions, McVail pointed to Camberwell infirmary which undertook 500 operations a year and was equipped with 'a fine modern operating theatre' (Cd. 4573: 39). He also thought that claims that 'infirm' cases were being 'driven out' of this infirmary had 'a good deal of foundation' (ibid.: 40). In contrast other infirmaries like King's Norton and Kingston Upon Hull undertook little or no surgical work (ibid. 45-6; see also, ibid: 47 for comparisons of the equipment available in these hospitals). Thus even in this period there were some Poor Law institutions which were taking on 'general' hospital characteristics rather than concentrating on care for the chronic sick.

This did not eliminate inter-sectoral differences. For example, McVail estimated that even Camberwell undertook only roughly one eighth of the level of operations which

would be expected of a [non Poor Law] general hospital of equivalent size (ibid.: 45).

However, it did begin to create a new set of relations between the sectors. The division of labour outlined above posited a complementary relationship between voluntary and municipal hospitals whereas the emergence public general hospitals meant that they became potentially an *alternative* to voluntary provision.

This pattern was accelerated in the inter-war period. Thus it has been pointed out that Poor Law medical institutions were increasingly designated 'hospitals' rather than using terms such as 'parish' or 'union' in their titles, with obvious Poor Law connotations (Crowther, 1981: 183). However, the major impetus to this shift came with the Local Government Act of 1929 which empowered county and county borough councils to take over or 'appropriate' Poor Law hospitals. Where such a shift took place institutions came under the remit of the local authority public health committee. This not only formally separated them from public assistance but it allowed for the possibility (where the local authority had the resources and the political inclination) to considerably improve standards of equipment and staffing.

The Local Government Act, as it applied to medical services, has to be seen in a context of the increasing importance of general hospital treatment. Thus Table 4.1 shows that, although the proportion of teaching and general beds in the voluntary sector only increased slightly (from 65.48 per cent to 66.5 per cent) as overall bed numbers increased substantially, so did teaching and general bed provision. Consequently bed *numbers* in these categories increased from from 37,027 in 1921 to 58,007 in 1938. This itself understates the expansion of hospital treatment of this type since there was also the continuation of the long term trend to reduce length of stay. For example, Pinker (1966:

116) shows that average length of stay fell from 20.4 to 17.8 days in voluntary teaching and from 23.8 to 17.3 in general non-teaching hospitals between 1921 and 1938. Thus the number of patients treated expanded at a faster rate than the expansion of bed provision.

There is also evidence of similar trends in the public sector. Thus, for example, Powell (1997a: 344) points out that while bed numbers in municipal hospitals in England increased by only 4.4 per cent from 1931 to 1938, admissions rose by 37.3 per cent, operations performed by 73.6 per cent and out-patient attendances by 191.8 per cent.

Inter-Sectoral Tensions

However, while this shift to the increased importance of hospitals and in particular general hospitals led to substantial increases in public access they also generated tensions between the sectors. Section 13 of the 1929 Local Government Act required that county and country borough councils should consult with representatives of the voluntary sector regarding 'accommodation to be provided and...the purposes for which it is to be used'. However, this was not a bi-partisan measure but was instigated by voluntary hospital interests via an amendment introduced in the House of Lords in March 1929 (Webster, 1990a: 126).

No reciprocal obligation was imposed on the voluntary hospitals (Rivett, 1986: 206) and the Clause can be seen as a means to constrain a potentially threatening development from the voluntary sector standpoint. Thus, Sir Frederick Menzies, the Chief Medical Officer of the London County Council (LCC) recalled that, at the first meeting between the Voluntary Hospitals Statutory Commission and the LCC in 1930, the Chair of the former, Lord Riddell, President of the Royal Free Hospital (Rivett, 1986: 208), expressed the view that the LCC should fulfill its duties under the 1929 Local Government Act by

concentrating on providing care for the chronically sick and infirm. LCC acute patients should be transferred to the voluntary hospitals and the local authority should make grants to voluntary hospitals to fund such treatment (Menzie's, Memorandum on Hospital Policy in London, August 1941, PRO, MH 77/25).

The Financing of Voluntary Hospitals

To understand the tensions between the two sectors, in the context of public hospitals emerging as competitors to the voluntary sector, it is necessary to examine another important change in the inter-war period, that in the pattern of financing of the voluntary sector. A central trend in this respect was the increasing importance of wage-earner based contributory schemes and payments by private patients. Cherry (1997: 310 and 314) classifies voluntary sector maintenance income, i.e. financing regular running costs, into two parts: 'ordinary income' stemming from small donations, subscriptions, income from investments, income from collections and patients payments; and 'extraordinary' income, from 'free' legacies to which no specific conditions were attached. The ability of voluntary sector hospitals to fund their regular running costs was predominantly dependent on 'ordinary' income.

Cherry (1997) shows that, across the voluntary sector, the dependence on collecting schemes and patient payments increased in the inter-war period but that this process was uneven. It went furthest in the provincial voluntary hospitals of England and Wales where the share of 'ordinary' income from these sources increased from 38.5 per cent in the 1920-4 period to 56.8 per cent (ibid.: 314). In the case of individual hospitals or groups of hospitals even higher levels of dependence have been found. Thus, over the period 1930-

6, four Sheffield voluntary hospitals derived 70 per cent of their ordinary income from works collection and contributory schemes' (Cherry, 1996: 233).

The same trend was evident in London voluntary hospitals but was less marked with an increase in collecting scheme/patient payment share of ordinary income from 29 per cent 1920-4 to 38 per cent 1935-8 (*ibid.*: 221). Dependence on such sources was least in the Scottish voluntary hospitals where the share of ordinary income increased from 25 per cent (1920-4) to 33 per cent (1935-8) (*ibid.*). Cherry (1997: 320) also points to the links between success in tapping contributory sources and the stability of voluntary hospital finances: 'those provincial teaching hospitals running the largest current account deficits (Manchester and Bristol) had the weakest contributory scheme networks and greatest surpluses (in Sheffield and Birmingham) reflected particularly strong contributory scheme support'.

Contributory and workplace collections involved quasi-insurance characteristics. For example, some took the form of regular deductions from wages charged at a given level, e.g. 1d. in the £ (Abel-Smith, 1964: 327). Equally Cherry's research (1996) has pointed to numerous examples of attempts, by representatives of collecting schemes, to influence patterns of voluntary hospital service provision. These included disputes over the location of a hospital in Doncaster (*ibid.*: 227-8); over access to hospital admission in Bedford and Northampton (*ibid.*: 225) and in Reading (*ibid.*: 226). In addition a common feature of such schemes was the exemption of members from payment if they were admitted to voluntary hospitals (Stone, 1939: 373).

The quasi insurance characteristic of this increasingly significant form of funding of voluntary hospitals is central to the tensions generated by the Local Government Act of

1929. The de facto division of labour between the two sectors would serve to support contributory schemes since general hospital treatment of a relatively high standard would be the effective preserve of the voluntary sector. However, a *competitive* public service raised pointed issues regarding the rationale for contributing to support voluntary hospitals when a public alternative of comparable standard was available.

If high quality public provision were free then the public sector became so much more competitive and the rationale for contributory schemes that much weaker. This source of inter-sectoral tension resurfaced in the wartime planning of a national health service.

Hospital Charges

The issue here was whether charges should apply to hospital patients and if so at what level and on what basis. In his statement on a future hospital service of October 9th 1941 Brown, the then Minister of Health, had referred to the expectation that patients would make a 'reasonable' contribution to hospital costs (Hansard, Parliamentary Debates, Commons, 1940-41, Vol. 374, Col. 1117). However, this issue divided opinion both amongst officials and politicians. Charges (or at least substantial charges) posed the threat of being a disincentive to seeking treatment which was contrary to the Beveridge principle that financial barriers ought not to apply to health services (Pater and McNicholl, Hospital Contributory Schemes and the Beveridge Scheme, 31st December 1942, PRO, MH 80/34).

The growth of contributory schemes referred to above raised the possibility of imposing charges with the scheme giving effective insurance cover to the member. Thus an option could have been to establish a regulatory framework where schemes meeting certain conditions were 'approved' and could provide the requisite cover. However, if

membership of an approved scheme was optional then non-members would have to be subject to a test of means. Yet, in turn, both voluntary and municipal hospital experience was that returns from such a method were unsatisfactory. This meant that that reliance on a combination of approved contributory schemes and means tests 'would...create difficulties if any larger number of non-contributory patients found it possible to elude their reasonable obligations by remaining outside "approved" contributory schemes' (No Author, Notes on Methods of Obtaining From Patients' Contributions in Respect of Hospital Treatment and Maintenance, 28th April 1942, PRO, MH 80/34). This also had potential for undermining contributory schemes since problems of enforcement reduced the likelihood of having to pay for hospital services.

An alternative was to make membership of such schemes compulsory, in effect a kind of reinvention of inter-war National Health Insurance (NHI). However, the problem here was that a future NHS was to be universal and thus resolve problems of inadequate coverage. In contrast NHI worked by basing entitlement on labour market participation but a return to this basis would not be tenable since 'a large section of those who require and receive hospital treatment would be excluded' (No Author, Memorandum – Contributory Schemes, May 1942, PRO, MH 80/34).

Pater and McNicholl's paper on hospital contributory schemes which raised a number of these arguments, did not rule out charges. However, they wanted a modest 'hotel' charge. In the paper this was set at 10/- (50p) but with a lower rate for children and a higher level for adults with no dependants. They proposed that acute and maternity hospitals in the voluntary and public sectors should receive an income from such 'hotel' charges and a part of the funding from national insurance contributions. Tuberculosis, infectious disease

and chronic sickness hospitals were not to receive insurance funding but were to make a 'hotel' charge. With respect to the voluntary sector these sources were seen as replacing the income derived from contributory schemes and they sought to demonstrate that these alternative sources of funding would be satisfactory by comparing expected revenue from these sources with pre-war income from voluntary contributory schemes (Pater and McNicholl, Hospital Contributory Schemes and the Beveridge Plan, 31st December 1942, PRO, MH 80/34).

The main critic, amongst officials, of such a strategy was Sir John Maude who argued both for higher charges and a continued reliance on contributory schemes. Approaches like those of Pater and McNicholl assumed that a substantial contribution to funding hospital costs would come from national insurance contributions. Maude was sceptical of this approach on the grounds that such contributions would have to go higher but were '...already very high for the lower paid workers'. He also stressed the impact of free hospital care on voluntary contributory schemes: '...if everyone could go to a hospital without liabilities for any payment the *raison d'être* of the voluntary hospital contributory schemes would disappear' (Maude, National Health Service Payment by Patients in Hospital, PRO, MH 80/34). The logic of Maude's position was that charges would have to be set at a level which would underpin membership of voluntary schemes. Thus in discussing the option of imposing a 'substantial charge'. He cited a figure of £2 per week, roughly four times the 'hotel' charge level (Maude, Should Hospital Treatment be Free of Charge?, 28th February 1943, PRO, MH 80/25).

These divisions amongst officials were also mirrored in political differences, in particular between the Ministers of Health, Brown (National Liberal) and Willink

(Conservative) on one side; and the (Labour) Secretary of State for Scotland, Johnston on the other. At the meeting of the Reconstruction Priorities Committee of the War Cabinet of 1st November 1943 Johnston proposed charges of 7/- (35p) for a married man and 10/- (50p) for an unmarried man but this was only to apply to disability benefit claimants after the fourth week of benefit (War Cabinet Committee on Reconstruction Priorities, Conclusions of the Committee Held 1st November 1943, P. R. (43), 29th Meeting, PRO, MH 80/34). In contrast, at the same meeting, Brown supported charges on the basis of their link with the viability of voluntary contributory schemes. The Chancellor (Anderson) supported a 10/- (50p) charge and suggested the possibility of withdrawing part of the children's allowance when a child was in hospital. He also raised the option of higher national insurance contributions. The minutes record 'general agreement' with Anderson's proposals which were closer to Johnston's stance (*ibid.*).

The divisions were again expressed at a meeting of the Reconstruction Priorities Committee of 3rd January 1944. Willink, the new Minister of Health, argued for a £1 per week hospital charge. If individuals were scheme members the charge would be remitted or an 'appropriate proportion' paid but Johnston reiterated his opposition. However, on one aspect of policy there was general agreement. Whatever was decided it had to be uniform '...the matter is one on which similar proposals must be made for the two countries and on which the White Paper cannot be ambiguous' (War Cabinet Reconstruction Priorities Committee, Memorandum by the Minister of Health and the Secretary of State for Scotland, Draft White Paper on the New Health Service, 3rd January 1944, R (44) 2, PRO, MH 80/27).

The final resolution came at the Reconstruction Priorities Committee one week later. In the end the 'general feeling' was 'that it would be illogical to require additional payment for these purposes [treatment/maintenance in hospitals] when what was claimed to be a comprehensive health service was being introduced' (War Cabinet, Reconstruction Priorities Committee Minutes, 10th January 1944, PRO, MH 80/27). As Honigsbaum (1989: 163) points out this decision determined the position in the 1944 White Paper. The only charges referred to were for 'certain appliances' and the possibility of a deduction from disability benefit was raised to be dealt with as part of the social insurance proposals (Cmd. 6502: 46).

This decision meant that a post-war hospital service would, overwhelmingly, be financed from public funds. Charges, if they were to operate at all, were to be of marginal significance and, insofar as contributory schemes would continue they would lose their insurance character. Since there would be little or nothing in the way of charges there was correspondingly no basis for insurance. However, this meant that the political importance of the estimates of future hospital costs also became that much more significant. In the next section the aim is to examine how these cost estimates were prepared.

The Hospital Cost Estimates

The Approximate Cost Estimate

Table 4.3 shows the expected cost of the hospital service as presented in the Approximate Cost estimate. As the Table indicates, this estimate presupposed that, out of a total expenditure of £64 million, £11.8 million (18.4 per cent) would come from 'private' sources.

Table 4.3: Estimate of the Cost of the Hospital Service (England and Wales) in the 'Approximate Cost' Document (£ million)

Hospital Type	Cost to Public Funds	Total Cost
Public Hospitals (other than Mental/'Mental Deficiency')	27.0	30.0
Voluntary Hospitals	10.7	18.0
Total (hospitals for physically ill)	37.7	48.0
Mental/'Mental Deficiency' Hospitals	14.5	16.0
Overall Total	52.5	64.0

Source: Approximate Cost of the Main Health Services, 29th July 1942, PRO, MH 80/24

With respect to voluntary hospitals it is clear, at this stage, that the a significant proportion of funding was assumed to derive from voluntary revenue thus £7.3 million (40.5 %) of total funding of such hospitals was expected to come from such sources.

The contemporary *Rough Estimate of the Net Cost to Public Funds of a Comprehensive Medical Service* document gave figures for the pre-war cost of local authority hospitals.

With respect to those for the physically ill (general, public assistance, tuberculosis and other infectious diseases) this gave an expenditure figure of £26 million 'pre war'.

Mental/'mental deficiency' hospital expenditure was put at £17 million and voluntary sector 'expenditure on maintenance' at £13.5 million. With respect to the latter a further figure for patients' contributions was put at £6.25 million (No Author, *Rough Estimate of the Net Cost to Public Funds of a Comprehensive Medical Service*, 29th July 1942, PRO, MH 80/24).

What is clear from such estimates is that, at this stage, hospital expenditure under a future NHS was conceived as being pitched at a similar aggregate level to that at the end of the inter-war period. Thus the £26 million cited for hospitals other than mental

illness/mental deficiency at the end of the inter-war period was slightly lower than the £30 million total cost and marginally below the £27 million cost to public funds cited in the Approximate Cost estimate. With respect to mental illness/'mental deficiency' the Approximate Cost figures are also lower than their Rough Estimate counterparts: £16 million, against the Rough Estimate £17 million; and the respective figures for voluntary hospitals are £18 million as against £19.75 million (aggregating for this last figure maintenance and patient contribution figures).

This picture of expenditure set at 'pre war' levels is also confirmed in other documents. At a conference on post-war hospital policy in December 1940 it was decided to undertake 'research which would have to be made before a definite policy could be formulated' (Post-War Hospital Policy, Conference, 7th December 1940, PRO, MH 80/24). This 'research' covered both the extent of hospital accommodation and costs of provision. Alford, George's predecessor as Accountant-General (British Imperial Calendar and Civil Service List, 1940: 85) who undertook the work reported figures of £47.2 million for hospital expenditure overall (all public and voluntary sector provision). This was roughly 10 per cent lower than the cost to public funds figure cited in the Approximate Cost estimate.

Thus what is clear is that, at this stage, the estimates did not involve the expectation of any dramatic increase in hospital expenditure over that prevailing at the end of the inter-war period. For example, the Approximate Cost total cost figure of £64 million contrasts with the Rough Cost estimate of pre-war expenditure of £62.75 million. Part of the reason for this could have been related to the view that standards of provision could be improved without any substantial increase in expenditure because of the organisational advantages

which would flow from a national health service. Thus while a paper by Pater, of April 1940, points to pressures for increased expenditure via payment of consultants and higher pay for nurses, he also argued ‘...there is little doubt that with proper organisation the present resources in money and material could provide a much better hospital service’ (Pater, Notes on Hospital Policy, 18th April 1940, PRO, MH 80/24).

The Finance of New Health Scheme Estimate

As Table 4.4 indicates this document simply divided hospital expenditure into two categories ‘general’ (encompassing municipal and voluntary) and ‘mental’ (covering mental illness and ‘mental deficiency’). The document indicates that part of this expenditure was derived from grants from the exchequer. Thus ‘general’ beds, estimated at 350,000 in the new service, would attract grant at £55 per bed per annum and mental/’mental deficiency’ beds would receive grant at £10 per bed per annum. This gave a total grant expenditure of £20,750,000 (£19,250,000, ‘general’ beds and £1.5 million mental/’mental deficiency’).

Table 4.4 Estimate of the Cost of the Hospital Service (England and Wales) in the Finance of New Health Scheme Document.

Type of Hospital	Estimate
General	£50m
Mental/’Mental Deficiency’	£19m
Total	£69m

Source: George to Maude, Finance of New Health Scheme, 24th September 1943, PRO, MH 80/26.

The status of the £55 grant was discussed at a meeting with local authority financial officers in April 1943. At this meeting George, had pointed out that it was ‘not related to

the cost of treatment but represented the estimated loss of contributory schemes' (Note of a Discussion with Financial Officers, 7th April 1943, PRO, MH 80/31). This statement can be related back to a July 1942 document on the *Financial Position of Voluntary Hospitals after the War* (29th July 1942, PRO, MH 80/24). This document had assumed a hotel charge of 15/- (75p) per week. As this was a patient payment it had to relate to occupied beds and that document had assumed a 75 per cent occupancy rate. The figure given in that document was 71,300 available beds in the voluntary sector for the new service. Assuming 75 per cent occupancy this would give 53,475 occupied beds with 'hotel' charge payments of £39 per year, a total of £2.08 million or £2.1 million, rounded up, as in the document. The same document gives a patient contribution figure of £6.3 million and thus an expected shortfall of £4.2 million. Applying the grant figure to the available beds would give £3.9 million, not quite full 'compensation' but roughly in line with the figures presented in the *Financial Position of Voluntary Hospitals After the War* document.

During the period between the Approximate Cost and Finance of New Health Scheme estimates meetings had taken place with representatives of the local authorities on plans for the new Service. In some of these meetings doubts were expressed by local authority representatives regarding the hospital cost assumptions in the Ministry estimates. A fuller discussion of these criticisms will be undertaken in the next section. There is no account given as to why the overall hospital cost estimate was slightly higher in the Finance of New Health Scheme. Possibly local authority doubts might have had some influence though it is again notable that the increase over the Approximate Cost estimate was still small.

The White Paper Estimate

Table 4.5 gives the 1944 White Paper estimate for hospital costs. This resulted in an overall estimate of £80 million, some 25 per cent higher than the Approximate Cost figure.

Table 4.5 Estimate of Hospital Costs (England and Wales) in the 1944 White Paper ‘A National Health Service’

Type of Hospital	Estimate
Municipal	£70m
Voluntary	£10m
Total	£80m

Source: Cmd. 6502

Part of this increase related to an upward shift in the general hospital grant figure from £55 per bed per annum to £100 and in the mental/’mental deficiency’ grant to £35 per bed per annum, from £10. This was partly compensated for by reducing the grant for infectious disease hospitals to £35 per bed per annum. However, this meant that overall grant expenditure climbed from £20.75 million in the Finance of New Health Scheme to £38.4 million in the White Paper.

In a first draft of the Financial Appendix to the White Paper, sent to Maude in November 1943, George commented on the shift in the grant figures. With respect to general hospitals he reiterated the rationale of compensating voluntary hospitals for loss of contributory income. This had already been encompassed, at least to the Ministry’s satisfaction, in the £55 grant. However, George also argued that the figure had been influenced by ‘criticism of the Local Authority representatives that the previously proposed grant towards costs of hospital treatment was inadequate’ (George to Secretary, 1st Draft of the Financial Appendix, 5th November 1943, MH 77/28).

The Critique of the White Paper Estimates

The object of this section is to discuss the criticisms levelled at the estimates of hospital costs contained in the White Paper. As has already been indicated, in explaining the increase in the grant figure for general hospitals contained in the White Paper George referred to criticisms made by local authority representatives that earlier estimates were too low to run an effective general hospital service. However, notwithstanding the higher grant and the increase of 25 per cent in the overall estimate between the Approximate Cost figure and the White Paper, the latter estimate was also criticised as being unrealistically low.

Robb-Smith's Critique

A key source for this Section is a critique of the White Paper estimates by Dr. A.H.T. Robb-Smith, then Director of Pathology at the Radcliffe Infirmary (Robb-Smith, 1944: 545), published in *The Lancet* in April 1944. Dr. Robb-Smith's papers are held at the Wellcome Institute for the History of Medicine. However, they do not contain material which throws further light on his interest in NHS expenditure. It would appear that this was a subject to which he did not return. His Curriculum Vitae is included amongst his papers and contains no reference to other publications on NHS costs after the 1944 article discussed in this section (GC 181/1). In addition Box 2 of his papers contains reprints of his articles for the 1929-47 period. It includes a reprint of the 1944 *Lancet* article but with no accompanying papers or correspondence related to it (GC 182/4/1). He died in January 2000 and his obituary in *The Times* makes no reference to the work on NHS expenditure discussed in this section (Unsigned, 2000: 27).

The White Paper anticipated both that the municipal hospital service would continue to be run and partly financed by local authorities; and that voluntary hospitals would enter into a quasi-contractual relation with the state and that, while they would be in receipt of state grant they would also supplement this income with one from voluntary sources. In his critical discussion of the White Paper Robb-Smith (1944) sought to use a reasonable set of assumptions which would allow a figure for expected general hospital unit costs to be constructed. The White Paper included 210,000 'other municipal beds' in the new Service and these general hospital beds were to be funded at a grant of £100 per bed per annum (Cmd. 6502: 82). It also cited an expenditure figure for such hospitals in 1938 of £14.6 m (ibid.: 81). *Total* local authority hospital spending in 1938 (covering the above general hospitals and mental/'mental deficiency' institutions, infectious disease and tuberculosis provision) was stated to be £35.7m. in 1938. However, the White Paper expected this to rise to £41.6m under the new Service (ibid.: 82). Robb-Smith (1944: 545) argued that, if an assumption is made that expenditure on 'other hospitals and institutions' was the same proportion of total expenditure as in 1938, then it would rise to £17m under the new Service (£14.6m multiplied by $41.6/35.7$).

With respect to voluntary hospitals grant would also be at £100 per annum and it was expected that 100,000 beds would be available under the new Service from the voluntary sector. However, an additional assumption was required regarding the likely level of voluntary income. In his article Robb-Smith assumes that a further £6 million would come from this source (ibid.). He makes no attempt to justify this figure. In 1938 (data covering 71,320 beds) total voluntary hospital income in England and Wales was £12.1 m with £4.8 coming from voluntary gifts and investments and £7.3m. from payments for

services (Pinker, 1966: 149). The largest part of the latter (£6.3m) was accounted for by patient payments and revenue from subscription schemes (ibid.), Table 4.6 draws together the two calculations to give an expected cost per bed in general hospitals under the new Service.

Table 4.6 Reconstruction of Robb-Smith’s Calculation of Expected Cost Bed in Hospitals (England and Wales) Based on Data in the 1944 White Paper A National Health Service.

Hospital Type	Bed Numbers	Grant	Local or Voluntary Funding	Implied Cost Per In-Patient Year/Week
Municipal	210,000	£21 million	£17 million	
Voluntary	100,000	£10 million	£ 6 million	
Total	310,000	£31 million	£23 million	£174.20 per year; £3.35 per week

Source: Robb-Smith (1944)

Robb-Smith (ibid.: 545) commented, with respect to this figure that ‘unless the majority of beds were of “public assistance institution standard” £3 is certainly a good deal below the true figure’.

The Treatment of Inflation

However, before attempting to assess the validity of this argument it is necessary to examine whether the White Paper figures were intended to represent an estimate at expected post-war prices or whether it was assumed that an adjustment for wartime inflation would be *added*. The text of the White Paper suggests that the figures are to be taken as *not* requiring any inflationary adjustment. Thus, for example, discussing likely post-war hospital expenditure by joint boards of local authorities, the 1938-9 figure of £35.7 million is cited and it is argued: ‘after the war the 1938-9 cost will be considerably increased...In these circumstances the cost to the joint authorities of those services in the

years *immediately after the war* and of the general administrative expenses may approach £70 millions' (Cmd. 6502: 81, my emphasis). Thus, as £70 million was the White Paper figure for local authority hospital expenditure in England and Wales (ibid.: 82) it was intended that this should be treated as a 'post-war' figure.

Assessing the Critique

One of the difficulties with Robb-Smith's argument is that, while an implicit cost per bed per week figure is constructed from the White Paper data, no attempt is made to compare it with cost data in the voluntary or municipal sectors. With respect to his comment that the cost per bed figure was appropriate to a 'public assistance' institution he was implying that it could not sustain the quality of provision pre-supposed in the White Paper.

To evaluate this argument it is necessary to go back to the concept of service standards set out in that document. It begins with the following statement 'the Government have announced that they intend to establish a comprehensive health service....They want to ensure that in future every man, woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health; that what they get shall be the best medical and other facilities available.' (Cmd. 6502: 5, my emphasis).

One way in which 'the best' medical facilities might be interpreted was a 'levelling up' to the standards of the best provision at the end of the inter-war period. In the first section it was argued that hospital treatment was becoming increasingly central to health care provision in this period and this was linked to greater throughput of patients and reduced length of stay.

In this context ‘the best’ could be seen as exemplified in the voluntary sector by, the major teaching hospitals, particularly those in London; and in the public sector by those local authorities which had made most use of their public health powers under the Local Government Act of 1929. With respect to the latter the classic example was the London County Council (LCC) which, following Labours local election victory in 1934, had pressed ahead with attempts to improve hospital standards in a financially well endowed local authority. Table 4.7 gives cost per in-patient week data for the London teaching hospitals for 1938 and the average cost per in-patient week data for the LCC general hospitals in 1937-8. Before examining this data it is necessary to make another qualifying comment. The data refers to cost per *in-patient* week. In contrast the White Paper figures refer to the *total cost* of hospital provision including *out-patients*. This means that the de facto cost per in-patient week given in Table 4.6 should be *lower*. However, the data does not allow for any rigorous adjustment of the cost figure but it should be borne in mind, when considering the argument developed below, that such a ‘favourable’ treatment of the White Paper figure has been made.

Table 4.7 Costs Per In-Patient Week, London Teaching Hospitals (1938) and London County Council General Hospitals (1938).

Hospital	Available Beds	Percentage of Occupied Beds	Cost Per In-Patient Week
Charing Cross	290	88.24	£4.50
Guy's	687	84.80	£6.18
King's College	382	86.44	£5.31
London	885	84.14	£5.62
Middlesex	601	95.02	£5.33
Royal Free	312	90.64	£5.00
St. Bartholomew's	726	89.42	£5.57
St. George's	330	85.03	£5.04
St. Mary's	460	84.76	£4.56
St. Thomas's	659	90.12	£5.11
University College	592	91.49	£4.72
Westminster	257	88.99	£5.92
LCC (general hospitals)	17,931	87.30	£4.11

Source: British Hospitals Association 1940; London County Council (1938)

What is clear from the Table is the extent of the divergence between the de facto White Paper cost norm and cost per in-patient week in London municipal and voluntary hospitals. It is also worth noting the occupancy rates in these hospitals. A relatively high in-patient cost per week could reflect very low occupancy levels. In such cases various fixed or semi-fixed costs are spread over a small patient population. Furthermore in the cost data in the Hospitals Yearbook 1940, it is possible to find hospitals combining very low occupancy rates with high costs per in-patient week. For example, Weir Hospital and Twickenham St. Johns were small hospitals with 30 and 34 beds respectively, with costs per in-patient week of £4.27 and £4.72 (British Hospitals Association, 1940: 129). They, however, operated with occupancy rates of 24.3 and 27.1 per cent respectively (ibid.: 106). In contrast the lowest occupancy rate in the London teaching hospitals in 1938 was 84.14 per cent and the LCC general hospital average was 87.3 per cent.

This meant that, while cost and standards of performance were by no means inexorably linked, the leading London teaching and municipal general hospitals were combining high levels of activity and high cost per in-patient week. The link between the two was related to the costs of a more interventionist medical approach. Thus, for example, Sir Frederick Menzies, County Medical Officer of Health to the LCC argued in his 1937-8 report ‘...the number of admissions and the average length of stay in hospital are in some measure a reflection of the intensity of work at the hospital and of the demands upon the staff, which in turn are likely to affect the numbers of such staff’ (London County Council, 1938:6).

Thus the ‘best’ standards of the end of the inter-war period could be seen as reflected in nursing staffing and as well as medical staffing levels since, to achieve higher levels of throughput, it was essential to deploy nurses to economise on the working time of doctors. So far the discussion has focused the cost of provision in London and the fact that it was, in both voluntary and municipal sectors, well in excess of the implied White Paper norm. It was the case, however, that costs in provincial hospitals were lower. In the public sector of 35 general hospitals administered by county boroughs for which cost data was available in 1938, only 5 (Birmingham, Dudley Road and Selly Oak; Cardiff, Llandough; Derby City and Smethick, St. Chad’s) had costs per in-patient week in excess of £3.50 in 1938. However, if these provincial hospitals are compared with the LCC then, not surprisingly given the importance of nurses as the major part of the healthcare workforce, lower provincial costs went with lower nursing staffing levels. This is illustrated in Table 4.8.

Table 4.8 Nursing Staffing Levels in London County Council and in Selected General Hospitals run by County Boroughs, 1938.

	Available Beds	Occupied Beds	Nursing Staff	Nursing Staff Ratios	Percentage of Nurses State Registered
London County Council	19,085	16,505	7069	(a) 0.37 (b) 0.43*	36.4
County Borough General	21,728	17,606	5982	(a) 0.27 (b) 0.34*	24.1

* (a) nurses per available bed (b) nurses per occupied bed

Source: British Hospitals Association, 1940

It is also worth noting that the five county borough general hospitals with costs per in patient week in excess of £3.50 in 1938 all had nursing staff ratios *higher* than the LCC average for general hospitals. Thus Birmingham Dudley Road had a ratio of 0.43 per available and 0.48 per occupied bed; and the respective figures for Birmingham Selly Oak were 0.48 and 0.48 (over 100% capacity in this hospital); for Cardiff Llandough 0.43 and 0.56; Derby City 0.43 and 0.56; and Smethick St. Chad's 0.46 and 0.5 (calculated from British Hospitals Association, 1940: 164-5).

Raising Standards

With respect to the standards involved in defining 'best' provision the argument so far has considered only a 'levelling up' concept to 'best' existing practice at the end of the inter-war period. However, it is also important to consider a different conception, one in which 'best' existing practice was, itself, seen as inadequate. With respect to the second meaning of 'best' provision an interesting source is a report on norms of nursing staffing published by the King's Fund in 1945. In the Report a starting point was to examine the ratio of ward staff per hundred bed in 6 hospitals, all acute used for nurse training (King's

Fund, 1945: 9). Four of the hospitals had over 200 beds, the smallest had 112 and the largest over 700 (ibid.: 10). In the hospitals concerned staffing ratios varied from a low of 38.45 per 100 beds to a high of 53.55 (ibid.). However the report argued that there were a number of reasons why these standards were inadequate.

The first was working hours. At the hospitals concerned fortnightly working hours varied from 95 to 132 (ibid. 11). The report recalculated the staffing ratios on the assumption that nurses worked a 96 hour fortnight (though relevant data was only available for five of the hospitals). On this basis the highest ratio rose to 65 nurses per 100 beds (ibid.). However, observation at the hospitals concerned led the authors of the report to question whether this level was adequate. It was argued that training would not be satisfactory if staffing levels were too low. Thus, for example, nurses would be more likely to be allocated to wards on the basis of their training needs (rather than to fill staffing gaps) if staffing ratios were more generous (ibid.: 13). This led to the recommendation of a 70 nurse per 100 bed norm (ibid.).

Even this was regarded as unsatisfactory since it was argued to make insufficient allowance for theoretical as against in-hospital nurse training. If this was accommodated by allowing for 'block' release of nurses for training where they did not work then the staffing ratio would have to go up to 80 per 100 beds. Finally this figure only referred to ward duties but acute hospitals would require nurse staffing with respect to treatment of out-patients and operating theatre duties, the authors estimated that this would increase the required ratio to 96 per 100 beds or virtually a one to one ratio (ibid.: 15).

It is also worth setting these norms in the context of concerns over nurse recruitment in this period. A survey of working women and secondary school girls in 1943 was

designed to examine attitudes to nursing as a career. It found that only 37 per cent of working women and 34 per cent of schoolgirls had attitudes to nursing which were classed as 'favourable' (Box and Croft-White, 1943: 4); and 'long hours' and 'bad pay' were the most frequently mentioned 'disadvantages' to entering a nursing career (ibid.: 8). Thus the norms suggested had a long-term objective to establish conditions whereby sufficient nurses would be attracted to the profession as well attempting to support training and standards of patient care. Consequently, on this more exacting standard 'the best' represented a nursing staffing level over *double* that prevailing in the LCC general hospitals.

The Cost of a Consultant Service

There was also another important question regarding likely costs, that of the consultant service. No direct mention of this was made in the White Paper but, given that honorary appointments had been bound up with voluntary sources of finance, then it was unlikely that such appointments would survive in a service in which voluntary hospitals would receive, even on a conservative estimate, the majority of their funds from the state. Robb-Smith sought to calculate a figure for the cost of such a service. This was based on the assumption of 17 consultants per 100,000 population or a population ratio of 5,900:1 consultant. He also assumed that each consultant would require an assistant (Robb-Smith, 1944: 545). As to pay he thought consultants should earn £2,000 a year and assistants £1,000. Robb-Smith's assumptions on consultant ratios were higher than those adopted in the Ministry. Godber generated an estimate from his hospital survey work in the Sheffield and North Midlands area. He argued that 454 consultants would be required (as against 205 practising at the time of the survey) in the area, a population ratio of 1:8500

(Godber, Consultants, 7th March 1944, MH 80/27). Godber did not discuss the issue of assistants but if Robb-Smith’s assumption of one consultant to one assistant is taken as well as his expected pay levels, then the two estimates would involve the expenditure levels shown in Table 4.9.

Table 4.9: Estimates of the Cost of a Consultant Service (England and Wales)

Estimate	Consultant: Population Ratio	Consultant Numbers	Consultant Pay	Assistants’ Pay	Total Cost
Robb-Smith	1: 5900	7000	£14 million	£7 million	£21 million
Godber	1: 8500	4850	£ 9.7 million	£4.8 million	£14.5 million

Sources: Robb-Smith (1944); Godber, Consultants, 7th March 1944, PRO, MH 80/27, own calculations

Assessing the Estimates

Taken together the various strands of evidence considered so far suggests that there was powerful support for Robb-Smith’s claim that expected general hospital costs were too low, given the health policy objectives of the White Paper. In effect the White Paper assumed a cost per bed in general hospitals of roughly £3.35 per week (and this, as was indicated above, takes no account of out-patient work). As has been demonstrated, the lowest cost per in-patient week in the London teaching hospitals (Charing Cross) was 34 per cent higher than this norm and the highest (Guy’s) was 84 per cent higher. In the case of the LCC general hospitals average costs were 22 per cent higher. However as was pointed out above, the text of the White Paper suggests that the figures in the financial appendix were intended to represent post-war expenditure levels. In this case it would be appropriate to adjust the municipal and voluntary hospital expenditure figures to take account of price changes. For example, using the 25 per cent adjustment used to calculate the figures for the Beveridge Report the lowest teaching hospital figure would be 68 per

cent higher than the White Paper norm; the highest London teaching hospital 130 per cent higher and the LCC general hospitals average 53 per cent higher.

Equally, it can be argued that this was not merely indicative of a 'London problem'. In a conception of hospital provision where medical interventions in hospitals were seen as increasingly effective and hospitals as institutions were viewed as central to health policy there would be an emphasis on continuing and accelerating patient throughput and reduction in length of stay in hospital. However this generated further demands for medical staffing, in particular nurses, the largest component of the medical workforce. In this respect the London hospitals could be seen as exemplars of 'the best'. As was pointed out the LCC general hospitals had both higher nursing staffing ratios and a higher proportion of qualified nurses. Further, the urban provincial municipal general hospitals with the highest costs also had nursing staff ratios above the LCC general hospital average. However, as the discussion of the King's Fund report showed, even these staffing levels were criticised as insufficient. There was also, as Robb-Smith pointed out, a major omission from the White Paper, funding for a consultant service.

There was also an attempt to estimate a more realistic figure. Robb-Smith (1944: 545) argued that '...it is unlikely that the average cost per bed can be less than £3 15/- (£3.75p) per week' but this figure was 'exclusive of the consultant service'. As has been shown he thought that £21 million would be an appropriate figure for such a service. At the £3.75p per bed per week hospital provision was estimated by Robb-Smith (*ibid.*) to cost £58.5 million (although applying the 310,000 beds to this figure should have generated a cost of £60.4 million) and £21 million for the consultant service, a total cost

of £79.5 million. This contrasted with the £48 million to public funds in the White Paper (or £54 million if the additional £6 million voluntary income was included).

Robb-Smith's estimate (including the cost of consultants) gave an alternative cost norm or roughly £5 per bed per in-patient week. It is interesting to note that this was also the figure cited by the local authority representatives in their criticisms of Ministry estimate. Thus in a Memorandum from the three major local authority associations, in June 1943, it was claimed that costs per in-patient week in an 'up-to-date and well equipped hospital' would not be 'less than £5 per week'. This was argued on the basis that, while costs per in-patient week could be inflated in wartime by lower occupancy rates 'upgrading of hospitals for the purposes of the Emergency Hospitals Scheme may result in permanently increasing the costs of many of them very considerably above the pre-war standards' (Memorandum by the County Councils Association, the Association of Municipal Corporations and the London County Council, Proposed Financial Basis of the New Health Services, 21st July 1943, PRO, MH 80/31).

This Memorandum gives no basis for the £5 figure and, as was indicated earlier, Robb-Smith's consultant service costs involved staffing levels higher than those thought appropriate in Godber's estimate. However, it is also worth noting that his initial cost per in-patient week, £3.75, was, itself, low, certainly in the context of London experience. Thus a reasonable case could be made for a £5 norm, in certain respects it could be argued to be conservative, but even this implied general hospital expenditure substantially higher than that stipulated in the White Paper. Thus, if a convincing case could be made that the official estimates were much too low this raises the question as to

why such an under-estimate occurred. It is this issue which is addressed in the next section.

The View from a Distance: the Political Basis of the Cost Under-Estimates

In attempting to account for the under-estimate the argument will focus on political determinants. The first determinant concerns the institutional relationship between the Ministry and the bodies running hospitals. This was particularly crucial in the case of hospital costs because of their complexity involving , for example, the links between activity levels and case-mix and their connection to staffing levels in a variety of different categories.

There was some understanding of these issues in the Ministry. For example Alford had pointed to the lower costs per bed in municipal sector as against the voluntary sector as being rooted in the larger percentage of chronic/infirm patients treated in the public sector (Alford, Note on Pre-War Hospital Accommodation and Its Cost, PRO, MH 80/24). In addition, although the material was not presented in a systematic way, a later document of April 1942, contained data which ought to have raised concerns with respect to the Ministry cost estimates. This, for example, gave costs per in-patient week for 1938 of £5.11p in London teaching hospitals, £3.69 in voluntary general hospitals in London and £4.02 in a Manchester teaching hospital (No Author, Hospital Costs, 9th April 1942, PRO, MH 80/24). However, these cost figures which were substantially higher than those presupposed in the Approximate Cost estimate prepared three months later.

A Distant Relationship

This remoteness from operational realities was signalled in the Ministry. In a memo, probably of December 1940, by Wrigley, then a Principal Assistant Secretary in the

Ministry (British Imperial Calendar and Civil Service List, 1940: 185). He argued 'the present position of the department...in regard to knowledge of and supervision of the institutional hospital services of local authorities is inconsistent and unsatisfactory' (Wrigley, Hospital Service, undated but printed before a paper of 18th December 1940, PRO, MH 80/24). The root of this lack of supervision was in the 1929 Local Government Act which meant that 'it has been since 1930 the policy of the Ministry to leave much greater discretion to County Councils and County Borough Councils than was left to the Boards of Guardians'.

The key to this change, introduced by the 1929 Local Government Act, was the replacement of specific service grants to local authorities by the block grant. Thus, in introducing the bill in November 1928 Neville Chamberlain claimed 'one of the advantages of the block grant system as compared to the present system of percentage grants is that it will enable us to give a large discretion to local authorities in the conduct of their business' (Hansard, Parliamentary Debates, Commons, 26 November 1928, Col. 104). Chamberlain argued that specific grants implied tighter supervision since 'with every increased expenditure, even if it be of the smallest kind, it carries with it a corresponding increase in the amount taken from the Exchequer' (ibid.). In contrast the block grant did not trigger increased expenditure and was, hence, compatible with less supervision.

Wrigley concluded that, as a result of this distant relationship '...there has been little contact between the department and the provision made by local authorities for the sick e.g. in London a large municipal hospital service has been built up by the London County Council ...but I do not think...many questions could be answered about it' (Wrigley,

Hospital Service, undated but printed before a paper of 18th December 1940, PRO, MH 80/24; see also on this issue Honigsbaum 1989: 16).

If the structure created by the 1929 Act encouraged distance then a second key determinant was the continuation of this structure in plans for the NHS, particularly those embodied in the 1944 White Paper. Again the Ministry role was to be limited with respect to both the Service as a whole and the hospital service in particular. Planning and part of execution was to be the role of the joint authorities with the additional participation of the voluntary hospitals. This meant that the delivery of the standards in the White Paper rested with the joint authorities. Furthermore, this structure strongly reflected the biases in official thinking in the Ministry. For example, Honigsbaum (1989: 41-2) has pointed to the fact that ‘eight leading civil servants’ (including George and Wrigley) had joined the Ministry of Health in 1919 after previous service in Local Government Board and that such officials ‘...saw themselves as the main spokesmen for municipal interests in Whitehall’ (ibid: 42). Thus distance was reinforced by the congruence of official bias and the structure envisaged for the future service during the Second World War. The operational problems of running hospitals at a given cost level would not be a direct concern of the Ministry.

In turn this political framework had an important financial implication. Under the White Paper division of responsibilities not only was the Ministry’s political role limited but so was its financial role. Central government was, with respect to hospitals, simply concerned with supporting the service via grants. The effect of this relationship can be seen in the approach taken by the Ministry to estimates and negotiations with local authorities. Thus it has already been pointed out that George regarded the £55 per bed

grant in the Finance of New Health Scheme estimate as having no specific relationship with hospital running costs. It was rather a means of compensating voluntary hospitals for an anticipated reduction in their funding. All this, arguably, accounts for the paradox that, while cost data contradictory with the premises of the Ministry estimates was freely available, cited in internal documents and in criticisms by local authority representatives, this had little impact on the expected cost calculations. The Ministry did not see itself in a cost controlling role, it operated at a distance. However, inaccurate estimates were politically dangerous and, in the final section, the argument considers an important communication from Robb-Smith and the response of officials.

A Dangerous Benchmark?

In March 1944 Robb-Smith wrote to the Minister of Health, Willink regarding the White Paper cost estimates. He referred to them as 'quite inadequate' and went on to argue 'my concern is...having mentioned a figure in the White Paper it may be difficult to persuade the legislature to accept a considerable increase in this figure' (Robb-Smith to Willink, 23rd March 1944, PRO, MH 77/84). Robb-Smith anticipated that the low estimates would trigger over-runs which would then meet with political resistance to increased funding.

The letter received considerable attention from officials. In part the discussion was concerned with detailed aspects of Robb-Smith's critique. However, the central objection to his argument was not so much that his alternative estimates were unsound but rather that he had misunderstood the status of the figures in the financial appendix. Thus Pater argued 'It is made quite clear in the Appendix that all it does is to make a very tentative estimate of the cost of the service in the early years. But Mr. Robb-Smith seems to regard

it as an authoritative final pronouncement on what the Government is prepared to spend on a comprehensive service...' (Pater to George, 1st April 1944, PRO, MH 77/84).

In his reply George supported Pater's argument on Robb-Smith's misperception of the status of the figures (George to Pater, 6th April 1944, PRO, MH 77/84). This view was central to the reply and Reed, Willink's private secretary wrote on behalf of the Minister '...Mr. Willink feels that you may be reading into Appendix E rather more than is justifiable. The estimates in Appendix E are not a statement of what the Government are prepared to spend but an attempt to suggest what the actual costs might be in the early years of the service' (Reed to Robb-Smith, 11th April 1944, PRO, MH 77/84).

This line of argument raised two problems. The first was that the misunderstanding of the pre-war hospital costs meant that the low estimates had the potential for substantial cost over-runs. The second was that officials assumed that estimates such as those in the White Paper would not and should not be taken as benchmarks of what was regarded as an appropriate cost for the service. While it may have been cogent to argue that such estimates *should not* be treated in this way it was quite another thing to assume that they *would not*. Equally, arguably, the political dangers of low cost estimates were increasing. As was pointed out in the first section, the decision not to impose substantial charges meant that voluntary sector financial 'independence' was virtually ended. However, this did not prevent voluntary sector attempts to resist municipal control. This was an important ingredient in Bevan's decision to propose hospital 'nationalisation' in October 1945, a policy approved by the Cabinet in December of that year. Henceforth with the exception of very limited local authority services, the cost of the service would fall on central government. The distant relationship to financial control was coming to an end

and the potential political significance of expenditure benchmarks becoming increasingly salient.

Conclusion

The research discussed in this Chapter has yielded a number of important conclusions. Again the documentary research leads to a questioning of arguments in the literature. In particular the work on the hospital estimates shows how, far from extrapolating from end of inter-war experience in preparing the estimates, officials failed to grasp the significance of hospital cost data of that period which was available to them. If they had done so a much higher hospital cost estimate would have been produced.

A further important finding is the impact of the distant relationship between the Ministry and the bodies providing hospital services on cost estimates since it meant that there was little appreciation of the cost implications of acute hospital provision. This relationship reflected the hands off approach of the Ministry with respect to local authorities which has been noted by Honigsbaum (1989) and it was reinforced by the structure proposed in the 1944 White Paper. However, this structure was not the basis on which Aneurin Bevan framed his plans for a National Health Service. The impact of this new structure is discussed, in the context of the financial crisis of the early years of the NHS, in Chapter 5.

Chapter 5: 'Reading' the 'Crisis of Expenditure' 1948-1951

Introduction

The object of this Chapter is to discuss the disjuncture between the estimates of expected National Health Service (NHS) costs and expenditure out-turns under the 1945-51 Labour government. The thesis advanced is that the political effect of the cost over-runs during this period were structured by the a priori political standpoints of the key participants in the policy process. Broadly three key positions are distinguished: that of Aneurin Bevan; of the Treasury; and of Labour critics of Bevan, particularly Morrison and Gaitskell. The aim will be to show that what Webster (1988a: 133) has called the 'crisis of expenditure' was susceptible of a number of 'readings'. Thus in what sense, if any, NHS expenditure was 'out of control' was crucially related to the political assumptions which the key players brought to the evidence.

The Chapter is divided into four sections: the first looks at the crucial policy decision to 'nationalise' the hospitals and examines the first key post-war expenditure estimate contained in the Financial Memorandum to the (1946) National Health Service Bill. The second examines the trends in the NHS estimates and expenditure over the 1948-51 period, particularly concentrating on fiscal years 1948-9 and 1949-50. The third discusses the evidence on how the estimates for 1948-9 were prepared and the reasons for the disjuncture between estimates and expenditure. These three sections provide the context for the discussion of the political debate between the participants referred to above and allow for an understanding of the different readings of the expenditure situation and how NHS expenditure was constituted as a political problem. This analysis will be pursued in the fourth section which will also relate the arguments of the key participants in the

political debate to the evidence on expenditure trends 1948-51. The conclusion traces the relationship between views of the 'problem' of NHS expenditure and the political assumptions of key participants in the policy process.

Hospital Nationalisation and the Financial Memorandum Estimate

Part of the background to Bevan's decision to 'nationalise' hospital provision lay in the deadlock which occurred in the post White Paper negotiations on the Hospital Service. As was pointed out in Chapter 1, this involved substantial concessions to voluntary hospital interests. However, this, in turn, generated resistance from local authorities which could not be ignored by the Minister. Webster (1998: 12) has summed up the failure of the post White Paper negotiations as follows 'by this stage the health scheme was on the verge of becoming a particularly unhappy compromise, incapable of commanding support from any group and offensive to all'.

Bevan's proposal to nationalise the Hospital Service can be seen as having two aspects: to shift policy in a more socialist direction; and to find a means of resolving the failure of the post White Paper negotiations discussed above. Bevan's proposed solution was presented in a paper to the Cabinet of the 5th October 1945, The Future of Hospital Services (Cabinet Memorandum by the Minister of Health, CP (45)205, 5th October 1945, CAB 129/3, reprinted in Webster, 1991: 31-39). In the paper Bevan advocated taking both voluntary and municipal hospitals (ibid. 35-6) into public ownership and to finance the hospital service from revenue raised by central government.

Webster (1991: 3) has argued that 'hospital nationalisation...transferred the weight of funding the new health service to general taxation, thereby maximising the redistributive effects of the new health service'. In addition taking the voluntary hospitals into public

ownership could be seen as supporting the principle of a public health service against the claims to voluntary hospital autonomy. Thus Bevan stated in the Memorandum ‘the notion of the self-contained separate, independent “local hospital” is nowadays a complete anachronism’ (ibid.: 33). Bevan reinforced his argument by reference to the high level of voluntary hospital dependence on public funding: ‘from estimates formed in my Department it seems clear that the moneys which would have to flow into the voluntary hospitals from public funds...would...amount to 70 per cent or more [of their total funding]’ (ibid.: 32). Thus Bevan argued ‘I believe...that we must insist on the principle of public control accompanying the public financing of hospitals’ (ibid.).

However, this of itself did not involve central government control since the municipal control norm of the White Paper was, in principle, an option. Part of Bevan’s argument against going down this road also involved an appeal to socialist principles. A central objective of the NHS was to break with any concept of a residual service and to ‘universalise the best’ but ‘under any local government system - even if modified by joint boards or otherwise – there will be a better service in the richer areas, a worse service in the poorer’ (ibid.: 35)

Breaking the Deadlock

Bevan also claimed that the organisational implications of local control were inconsistent with what was politically acceptable. Bevan’s arguments in this respect were made in the context of the assumption, shared with the White Paper, that existing local authorities formed an inadequate basis for the new Service. Thus he argued: ‘areas are usually too small for the needs of the specialised services’ (ibid.: 33-4).

This still left the option of a 'reorganised form of local government unit to run the hospital service' (ibid.: 34). Bevan rejected a directly elected health authority as, inter alia, 'unlikely to attract polling interest' (ibid.: 35). The 1944 White Paper solution to the problem was to constitute the hospital authority from joint board of local authorities. However, Bevan pointed to 'the removal of local responsibility to two removes from the local electorate' (ibid.) in such a proposal; and to 'the intense unpopularity of...the system of precepting on other authorities' rates for the joint board's money' (ibid.). Thus he concluded that 'the right course is to nationalise the hospital services...' (ibid.). This approach sought to reconcile furthering a socialist health politics and generating a more acceptable political structure for hospital provision.

Hospital nationalisation was a contentious issue in the Cabinet and Bevan's principal antagonist, at the time of the key debates, was the Lord President of the Council, Herbert Morrison. He argued, in a Cabinet meeting of 18th October 1945, that Bevan's proposal was likely to mean, in the context of the nationalisation of utilities such as electricity and gas, that '...the fabric of local government might be dangerously weakened' (National Health Service, 18th October 1945, PRO, CAB 128/1). Morrison's concerns related to what he saw as a loss of major functions for local government but there were also some broader political differences between himself and Bevan. Morrison argued (ibid.) that voluntary hospitals should not be taken into public ownership since they would eventually come under public control. As Webster (1991: 13) has pointed out, Morrison 'advocated a more gradualistic approach to the development of the health service' and his approach to voluntary hospitals reflected this stance. In contrast Bevan argued that, if exchequer funding was to be provided to voluntary hospitals, this would underpin their

continued existence outside public control (National Health Service, 18th October 1945, PRO, CAB 128/1).

A weakness in Morrison's position was that it referred back to the structure which had caused the deadlock in the hospital negotiations (joint authorities). Many of the criticisms of joint authorities raised by Bevan had also been used by Morrison in discussions preceding the 1944 White Paper. He had stated that 'he felt grave misgivings about the proposed extension of the device of entrusting responsibility to joint bodies drawn from two or more local authorities' (War Cabinet Committee on Reconstruction Priorities, 30th July 1943, Conclusions PR (43), 16th Meeting. PRO, CAB 87/12). These objections reflected concerns regarding democratic accountability and precepting. With respect to the former Morrison argued 'these bodies were not directly responsible to the local...electors' (ibid.). In a later meeting of the same committee Morrison raised the issue of precepting thus joint authorities were said to involve 'the danger of giving indirectly elected authorities the right to levy rates by precept on their constituent elected authorities' (War Cabinet Committee on Reconstruction Priorities, 8th September 1943, Conclusions PR (43), 18th Meeting. PRO, CAB 87/12).).

Morrison's attempt to block hospital nationalisation was not successful. Attlee's summary of the 18th October 1945 Cabinet meeting was that the '...feeling in the Cabinet seemed to him to be generally in favour of the solution proposed by the Minister of Health' (National Health Service, 18th October 1945, PRO, CAB 128/1). Bevan's plan for nationalisation thus went forward but it had three important effects with respect to later debates on NHS expenditure.

The Effects of Nationalisation

The first was that the cost of the most expensive component of the Service was transferred to general taxation. One consequence of this was that the Treasury would be increasingly involved in issues of NHS expenditure. The second major effect was the sharpening of the division between Morrison and Bevan. Finally, while Bevan had proposed a bold solution to the problem of hospital organisation and had ‘anticipated an outcry both from voluntary hospitals and from the local authorities’ (Webster, 1991: 38) he also sought to defuse such criticism. This was done by arguing that at regional level (eventually via the fourteen regions formed) and through hospital management committees (termed District Committees in the 5th October 1945 paper) ‘the whole hospital service...would be centrally financed but under a system ensuring a free and flexible degree of decentralised responsibility’ (ibid.). This was Bevan’s attempt to head off criticisms that he was seeking to impose excessive central controls on the Service.

As will be discussed in more detail below, whether these two objectives could be delivered was a key issue in the later debate on NHS expenditure. It was also one which elicited criticisms by Morrison and from Treasury sources. Thus, at a Cabinet of 20th December 1945 Morrison argued that the autonomy which Bevan was proposing would lead to regional authorities being ‘tempted to press for more and more lavish expenditure at the expense of the exchequer, particularly as there would be no contribution from the rates to provide an incentive to economy’ (National Health Service, 20th October 1945, PRO, CAB 128/2). This argument was also put forward in the Treasury ‘it is...difficult to see how the normal accounting conventions could be combined with the degree of

delegation proposed by the Minister’ (Hale, National Health Service, 15th December 1945, PRO, T 161/1243).

In this period potential battle lines over NHS expenditure were drawn. The battle itself was triggered by the disjuncture between cost estimates and expenditure out-turns in particular in the fiscal years 1948-9 and 1949-50. However, before turning to the pattern of that disjuncture it is necessary to examine the first key post-war expenditure estimate, that given in the Financial Memorandum to the (1946) NHS Bill. In Table 5.1 this estimate (for England and Wales) is contrasted with that given in the 1944 White Paper.

The Financial Memorandum Estimate

Table 5.1 Comparison of Expected Cost of a National Health Service in the 1944 White Paper and the Financial Memorandum to the National Health Service Bill, 1946, Estimate for England and Wales.

Service Area	1944 White Paper Estimate	1946 Financial Memorandum Estimate
Hospitals	£80 million	£87 million
General Medical; Pharmaceutical; Dental and Ophthalmic	£41 million	£45 million
Local Authority	£10 million	£12 million
Superannuation/ Compensation	-	£ 8 million
Total	£132 million	£152 million

Sources: Cmd. 6502; and Financial Memorandum to the NHS Bill.

What is immediately striking is the similarity of the two overall figures. In particular, in accounting for the difference between the estimates for hospitals, George told Hale that the difference in the two estimates, the extras £7 million on the estimate, was to be explained by the ‘...cessation of voluntary contributions to voluntary hospitals’ (George to Hale, 7th December 1945, PRO, T 161/1243). This meant that the *total* resources anticipated for hospitals, would be the sum estimated in the 1944 White Paper. The

adjustment to which George referred substituted state funding for what had been assumed to be the revenue from voluntary sources (which would cease with nationalisation).

It was argued, in the last Chapter, that the hospital estimate in the 1944 White Paper was seriously understated in the light of data available at the time. The effective carrying over of this estimate into that included in the Financial Memorandum meant that the questionable figure in the White Paper was replicated in the first post-war estimate.

Equally, in Chapter 3 it was shown that the White Paper estimate probably presupposed a restricted Dental and Ophthalmic Service rather than universal provision; and that very conservative expenditure assumptions had been made with respect to the Ophthalmic Service. This meant that the 1944 White Paper Estimate, substantially incorporated in the 1946 Financial Memorandum, was a potentially dangerous standard. If this estimate was treated as a benchmark, in future debates on expenditure, then it could be used as a basis, however unrealistic, for pressing for expenditure restraint. Equally, as will be demonstrated in the final section of the Chapter, this figure *was* used in this way.

However, before this political debate is analysed it is necessary to turn to the gap between expenditure out-turns and estimates in the 1948-51 since this triggered the 'crisis of expenditure'.

Triggering the 'Crisis': NHS Estimates and Expenditure 1948-51

The object of this section is to trace the pattern of the relationship between estimates of NHS expenditure and expenditure levels on the Service during over the period 1948-51. A conception of this pattern is necessary to the argument in this Chapter because the disjuncture between estimates and expenditure triggered the emergence of a situation in

which NHS expenditure became a salient political issue. Table 5.2 gives the aggregate figures of estimates and expenditure in the first three fiscal years of the Service. As the Service began in July 1948 it is important to bear in mind that 1948-9 is a part-year estimate and expenditure figure. There are certain respects in which the figures used here, which are drawn from the Civil Estimates, are problematic from standpoint of the analysis of expenditure trends and an aspect of this issue will be discussed below. However, the figures are a useful starting point because the difference between estimates and expenditure in these accounts informed the emergence of NHS expenditure as a political ‘problem’.

Table 5.2 shows that, in both the first two fiscal years, expenditure substantially exceeded the estimated figure. These over-runs, in turn, manifested themselves politically in the need for supplementary expenditure votes in both these years (Webster, 1988a: 141 and 150).

Table 5.2: Aggregate Estimates of the Expected Cost of the National Health Service and Expenditure Out-Turns 1948-51 (Great Britain, £).

Year	Estimate	Out-turn
1948-49	198,376,000	275,904,452
1949-50	352,324,600	449,171,642
1950-51	464,514,000	465,019,300

Source: Civil Estimates Class V, 1948, 1949, 1950

The over-runs in the first two fiscal years were not a feature of all parts of the Service. Tables 5.3 and 5.4 looks give the figures for the five Service areas under (ultimate) central government control, Hospitals, the General Practitioner Service, Pharmaceuticals, the Dental Service and the Supplementary Ophthalmic Service. They show the proportion of the total cost over-run for the two years accounted for by each of these areas.

Table 5.3 Cost Over-Run (£) and Share of the Total NHS Cost Over-Run Accounted for by Each of Five Service Areas, 1948-49 (Great Britain).

Service Area	Cost Over-Run	Share of Total Cost Over-Run: Five Services
Hospitals	24,471,000	42.1 %
General Practitioner	2,300,000	3.9 %
Pharmaceutical	5,015,000	8.6 %
Dental	13,650,000	23.5 %
Supplementary Ophthalmic	12,640,000	21.7 %
Total	58,076,000	100 %

Source: Civil Estimates Class V, 1948, 1949 and own calculations

Table 5.4 Cost Over-Run (£) and Share of the Total NHS Cost Over-Run Accounted for by Each of Five Service Areas, 1949-50 (Great Britain).

Service Area	Cost Over-Run	Share of Total Cost Over-Run: Five Services
Hospitals	48,753,600	52.5 %
General Practitioner	1,345,000	1.4 %
Pharmaceutical	14,550,000	15.7 %
Dental	17,744,000	19.1 %
Supplementary Ophthalmic	10,455,000	11.2 %
Total	92,847,000	100 %

Source: Civil Estimates Class V, 1949, 1950 and own calculations

Two features are particularly significant here. The first is that there was a marked variation between service areas with respect to their contributions to the overall cost over-run. For example, in both fiscal years, the General Practitioner Service accounted for only a small proportion of the total over-run. The second salient aspect is the shifting pattern in terms of the relative significance of different service areas between the two years. In 1948-9 the Dental and Supplementary Ophthalmic over-runs accounted for 45.2 per cent of the total, but in 1949-50 this had fallen to 30.3 per cent. In contrast the share of the Hospital and the Pharmaceutical services in the over-run rose from 50.7 per cent to 68.1 per cent. What this meant was that there was not a single expenditure control 'problem' but rather there was a shift in emphasis between areas and, as will be discussed

in the final section, in the focus of the policy debate on the mechanisms designed to resolve the ‘crisis’.

Another important issue with respect to the cost over-runs is the extent of variation in the extent of the inaccuracy of the estimates. In particular a striking aspect of the 1948-49 figures was that the Dental and Supplementary Ophthalmic services were expected to account for only 5.3 per cent of total expenditure yet they also accounted for just over 45 per cent of the estimate-expenditure difference in the five services analysed above. Table 5.5 contrast the variances between expenditure and estimate in four of the five service areas for 1948-49. The General Practitioner area has been excluded because such variances were consistently very small.

Table 5.5 Variances between Estimates and Expenditure Across Hospital, Dental, Supplementary Ophthalmic and Pharmaceutical Services, Great Britain, 1948-49.

Service Area	Estimate	Out-Turn	Variance
Hospitals	120,606,000	145,077,500	20.3 %
Pharmaceutical	12,700,000	17,715.000	39.5 %
Dental	8,150,000	21,800,000	167.5 %
Supplementary Ophthalmic	2,330,000	14,970,000	542.4%

Source: Calculated from Civil Estimates, Class V, 1948 and 1949

Variance (see Appendix 1) here is measured by expenditure-estimate difference as a percentage of the estimate. What is striking is the scale of the variance in the Dental and Ophthalmic areas thus ‘explaining’ the situation in which the two areas with the lowest expected expenditure accounted for such a substantial proportion of the total cost over-run in the first fiscal year.

Table 5.6 gives the corresponding figures for 1949-50. The sharp reductions in variance in the Dental and Ophthalmic areas are related to substantially higher estimates when contrasted with the previous fiscal year. Thus the 1949-50 Dental estimate was over three

and a half times and the Supplementary Ophthalmic estimates over six times that for 1948-49 (Civil Estimates, Class V, 1949). It is worth noting that the hospital variance is comfortably the smallest of the four areas in both years. However, its overall significance derives from the fact that this small variance is of much the larger initial estimate. Thus in 1949-50 expected hospital expenditure was over three times the combined estimates for the other three service areas considered.

Table 5.6 Variances between Estimates and Expenditure Across Hospital, Dental, Supplementary Ophthalmic and Pharmaceutical Services, Great Britain, 1949-50.

Service Area	Estimate	Out-Turn	Variance
Hospitals	201,802,000	250,755,600	24.2 %
Pharmaceutical	20,800,000	35,350,000	70.0 %
Dental	30,404,000	48,648,000	60.0 %
Supplementary Ophthalmic	14,670,000	25,125,000	71.3 %

Source: Civil Estimates, Class V, 1949 and 1950 and own calculations

A feature which was emphasised at the beginning of this Chapter was that the expenditure figures could be ‘read’ in a variety of ways. However, as was pointed out in the Introduction, as early as January 1949, Morrison was pressing Attlee to initiate an inquiry into the workings of the National Health Service, with a view to permitting the Cabinet to exercise greater control over health policy Webster (1988a: 134). Such calls for action give the impression that NHS expenditure trends were *self-evidently* a political problem. One reason this could appear to be the case is that, in a relatively short period of time, expenditure levels had greatly exceeded those anticipated in the Financial Memorandum to the NHS Bill. Table 5.7 shows the relationship between expenditure levels in the first three fiscal years of the Service, giving here an annualised figure for 1948-49 and the Financial Memorandum estimate.

Table 5.7 Estimate of NHS Expenditure in the Financial Memorandum to the NHS Bill Contrasted with Expenditure Out-Turns 1948-51 (Great Britain, £million).

Financial Memorandum (Estimate)	174.0	100.0 (index)
1948-49 (Annualised)	333.8	191.8
1949-50	449.2	258.1
1950-51	465.0	267.2

Source: Financial Memorandum to the NHS Bill; Civil Estimates 1948-50; own calculations

Thus, by the first full year of the Service, expenditure levels were running at over two and half times those anticipated in the Financial Memorandum. However, these trends were susceptible of alternative interpretations. As was indicated above, the 1946 Financial Memorandum estimate derived from marginal revisions to that in the 1944 White Paper, an estimate which was seriously flawed.

Furthermore, a key element in the 1948-49 over-runs was the much higher than anticipated cost of Dental and Supplementary Ophthalmic services. As was pointed out in Chapter 3, they were both remunerated on a fee for service basis and thus expenditure out-turns could be misleading because work undertaken in a given financial year might not be paid for until the next. The issue of lags between the undertaking of work and payment would give a misleading picture of trends. Thus, if, for example, expenditure were allocated to the year in which the work was undertaken rather than the year in which payment was made this could serve to reduce expenditure differences between years and produce a smoother (and perhaps less ‘alarming’) expenditure trend.

A further aspect which is relevant to the discussion is that the considerable variations between estimates and expenditure occurred at the beginning of the Service which was envisaged as breaking with past patterns of provision in terms of coverage and quality; and of finance, by shifting to a Service substantially free at the point of use. Scope for

estimating error might thus be expected to be greater at this point. Indeed, as is shown in Table 5.9 if the focus is put on the overall variance between estimates and expenditure then a case could be made that there was a progressive trend towards increased *control* over expenditure since, by 1950-51 the difference between estimate and out-turn had virtually been eliminated.

Table 5.8: Overall Variance Between NHS Estimates and Expenditure, Great Britain 1948-51.

Year	Variance
1948-49	40.3 %
1949-50	27.5 %
1950-51	0.1 %

Source: Calculated from data in Table 5.2

The aim of this Section has been to show that cost over-runs did not self-evidently constitute a political ‘problem’. How they were interpreted will be discussed in the final section. However, before turning to this it is necessary to examine a central feature of the ‘crisis of expenditure’. If the latter was triggered by the differences between estimates and expenditure out-turns this raises the issue of why the estimates were inaccurate. In turn this requires a discussion of how the estimates were prepared and it is this issue which is addressed in the next section.

The 1948-9 Estimates

The object of this section is to discuss how the estimates for the first (part) year of the Service were constructed and how the problems of cost under-estimates arose. It is important to stress that there is an extreme paucity of documentary sources for this estimate, a feature which has been confirmed by the author of the official history of the Service, Dr. Charles Webster (personal communication) and it seems likely that the documents concerned have been destroyed. Given this limitation the account is primarily

reliant on the 7th Report of the Select Committee on Estimates and, particularly, the evidence given to this Committee. Evidence was taken between 18th January and 22nd March 1949 and covered all major areas of the Service. The key sources of evidence on the approach to the estimates came, for the Ministry of Health, from George, the Accountant-General and for the Department of Health for Scotland, from Sir George Henderson, the Permanent Secretary. In addition evidence on hospital costs was given by individuals serving on Regional Hospitals Boards, Boards of Governors of teaching hospitals and Hospital Management Committees.

General Practice

The one area in which under-estimation was (virtually) a non-problem was the General Practitioner service. In fact, for the 1948-9 period in Scotland out-turn and estimate for the General Practitioner service were identical (Select Committee on Estimates, 1949: xi). Two features contributed to the ease of control in this area. The first, which was signalled in Chapter 2, was that a total pay pool figure for GPs was calculated. This was based on a 95 per cent population coverage assumption and thus did not vary with actual take-up by the population. A capitation fee rate of 18/- (90p) per patient was assumed in setting the pool figure although actual capitation payments to doctors were lower because a deduction from the pool was made for a mileage fund for doctors and a sum set aside to supplement the earnings of rural doctors (*ibid.*: xii and qu. 149). After these deductions the remaining funds were distributed to Executive Councils and they deducted the sum allocated for 'fixed annual payments'. This was in effect a basic salary element for which doctors could apply to the Executive Council and, if they were rejected, could appeal to the Minister (*ibid.*: xii).

The operation of the pool meant that a de facto cash limit operated with respect to this part of the Service. The pool was also designed to be related to a broad norm for GP pay and thus there was potential for a significant over-estimate if, for example, the income level presupposed in setting the pool diverged from a subsequently determined pay norm. This was crucial to the second feature affecting the accuracy of the general practice estimate. The Spens report on the remuneration of GPs which established the pay norm reported in July 1946 (Webster, 1990b: 206). The Spens recommendations were at pre-war prices and the eventual 18/- (90p) capitation fee was not finally accepted by the profession until May 1948 (ibid.: 209). However, Bevan proposed this figure as a final offer and Cripps had given him his support in November 1947. The 1948-9 estimates were prepared in the Autumn of 1947 thus it is likely that the Ministry had an accurate capitation figure to work with.

The combination of the two features provided the conditions for relatively unproblematic forecasting. As George explained to the Committee where under-estimates occurred this was not because the amounts *due* to doctors were inaccurate but rather that payments were made to them somewhat more quickly than had been anticipated (Select Committee on Estimates, 1949: qu. 193). The fact that the payments were made on a capitation basis did not pose a forecasting problem since, as they related to a pre-set population norm, the level of actual patient registration would not affect the size of the pool. Thus, with respect to the 1948-9 estimates general practice posed no significant problems. Quite the opposite was the case in the Dental and Ophthalmic services.

Dental and Ophthalmic Services

In these service areas NHS expenditure was designed to cover provision for the 'non-priority' groups. In both cases the mode of payment was on a fee for service and/or

appliance basis; for example for fillings or the provision of dentures in the dental area and sight-testing and the provision of spectacles in the ophthalmic area. As a consequence annual expenditure levels were determined by three features: the level of demand for the services; the cost per case or unit of service; and the time lags between the undertaking of work and when payment was made.

In the 1948-9 estimates for England a figure of expected expenditure for the dental service of £7 million was given. When asked by the Select Committee how this figure had been arrived at George gave the following account. The non priority population coverage was 30 million and the expected demand figure was generated by starting from the National Health Insurance (NHI) take-up rate of 7 per cent. However, as was pointed out in Chapter 3, the terms of NHI coverage were distinct from those envisaged under the NHS because approved society members usually contributed part of treatment and appliance costs. In addition the limitation on coverage to NHI contributors meant that substantial numbers would either not have obtained treatment or when it was available it was likely to be unsatisfactory. This meant that there was a potential backlog of demand and the new Service was, unlike NHI, to be free at the point of use. All this meant that NHI take-up levels might not be a realistic guide to NHS demand.

Consequently George, referring to the NHI take-up rate referred to above, told the Select Committee ‘we thought it was a bit low, that more people might take advantage of it [the dental service]’ (Select Committee on Estimates, 1949: Qu. 309). The cost per case figure used in the calculation was £4 per case. A 7 per cent take up rate at this cost per case figure would give an annual expenditure figure of roughly £8.5 million (2.1 million cases, 7 per cent of 30 million). However, the effect of the assumption that the

NHI take-up rate was ‘too low’ meant that the revised figure was £12 million annually (ibid.). George did not cite an expected take-up rate but, given the cost per case figure, this meant 3 million cases a year or a take-up rate of 10 per cent (given the 30 million ‘non priority’ population). This assumed take-up figure was also similar to the one used for Scotland. Thus Sir George Henderson stated that the NHI rate was revised upwards by 50 per cent as the basis of calculating the Scottish figure, which would have given an expected take-up of 10.5 per cent (ibid.). It is interesting to note how low these figures were when contrasted to the estimate of July 1942 discussed in Chapter 3, which showed that a 20 per cent take-up rate was envisaged in one scenario.

The £7 million estimate for England was derived by two further adjustments. The £12 million was an *annual* figure but the 1948-9 estimate referred not to a full fiscal year but to a part-year. This led to an adjustment down to £9 million as the service ran for roughly nine months in 1948-9. (ibid.). Finally, there was the issue of payments lags and, without any explanation of the basis for the downward revision, George assumed that *payments* of £7 million would be made in 1948-9 with respect to the dental service.

In the case of the Supplementary Ophthalmic service again the same ‘non-priority’ population group was to be covered. In this case the estimate for 1948-9 was £2 million. Asked about how this estimate was derived George replied: ‘I remember that we put demand at about 5 per cent, and we assumed for a whole year the cost would come to about £3 and a half millions on the basis of National Health Insurance experience. It was a very low rate. We estimated for nine months and for a lag in payment, and as the basis was so “hypothetical” we just put in £2 millions and did not try to be more accurate’ (ibid.: Qu. 556).

In an answer to an earlier question George pointed out that the estimates were made on the basis of the assumption of a cost per pair of spectacles of 40-45 shillings (£2-2.25). A 5 per cent take up would give 1.5 million cases per year and the (upper) cost figure would give a total cost of £3,375,000. A nine month variant of this figure would be £2.5 million and a similar reduction for lags to that applied for the dental service would give £2 million.

As was pointed out in the last section, in terms of variances between estimates and expenditure, the Dental and Ophthalmic services were those where the most serious under-estimates occurred. Not surprisingly the Select Committee asked why this had happened. In accounting for the disjuncture in the dental area George referred to the fact that, unlike the case of GPs, key data on remuneration was not available.

Recommendations on the remuneration of dentists were also made by a committee chaired by Sir Will Spens but its report was not available when the estimates were prepared (Select Committee on Estimates, 1949: xiv). As a result whereas the estimate had assumed a cost per case of £4 the correct figure was, George stated, 'just over £5'. Similarly, whereas the average cost of spectacles had been put at 40-45s (£2-25) this turned out to be 65/6 (£3.27) (*ibid.*: xvii).

This meant that the expected 'unit' costs were, respectively 25 and, roughly, 50 per cent higher than those assumed in the service estimates. However, as was indicated in the last section, the size of the variances in these two areas meant that higher than expected costs per service unit were secondary in importance behind the under-estimation of demand.

Thus, George referred to a demand level of 180,000 dental cases per week in 1948-9 (*ibid.* qu. 434) which would have translated to 9.3 million on an annual basis, over three

times the expected demand level. He also cited 3,422,000 cases for the first seven months of the Supplementary Ophthalmic service (ibid.: qu. 668) an annual rate of 5.8 million, just over four times the expected rate. As the Committee evidence was taken before the end of the fiscal year the figures were only provisional but they given an indication of the scale of the under-estimate.

With respect to both services George made reference to backlogs in demand. For example, with respect to the dental service he stated: 'I suppose a lot of people whose dentures were not fitting them very well and who could not find the money conveniently went to get proper fitting dentures' (ibid.: qu. 315). However, he also pointed to difficulties in translating an expectation that demand could rise on this basis into a more precise calculation of the likely *level* of that demand. Thus he argued: 'we all knew stories of people using spectacles handed down by Grannie on buying them in Woolworths but you cannot do statistical work on that basis' (ibid.: qu. 606).

Clearly cost estimates in the Dental and Ophthalmic Services posed problems of a quite different order from those involved in the General Practice area and inaccuracies were to be expected in the transition to a new type of service. However, there are difficulties with some of the arguments advanced by George. While cost per unit of service was, as has been pointed out, of secondary importance in accounting for the cost over-runs the figure used for the dental estimates appears strange. Thus a £4 per case assumption was used when average cost per case was £4.27 *at the end of the inter-war period* (see Chapter 3). Also it is worth noting that George probably under-estimated the actual cost per case at the outset of the service. His evidence on dental costs was given on the 1st February 1949 before the end of the fiscal year. The Public Record Office archive contains a file (MH

137/80) which gives a statistical series on Executive Council services and this gives an average cost per dental estimate of £5.40 in England and Wales for 1948-9 (No Author, November 1958, General Dental Service (England and Wales) Financial and Statistical Information from 5th June 1948, PRO, MH 137/80).

George argued that an awareness of backlogs and the effects of a service free at the point of use could boost demand but this would not indicate precisely how large this boost would be. This was undoubtedly sound. However, there was no attempt to consider whether there might have been alternative ways to estimate demand other than the (necessarily) speculative adjustments of NHI rates. A possibility was the use of social surveys. Thus, in addition to the survey of attitudes to nursing discussed in Chapter 4, the Wartime Social Surveys also undertook work related to use of public services. This included a study of how people got to work (Box, 1943); and, in the health field, the use of fruit juice and cod liver oil by children (Wagner and Reynolds, 1943).

There is also another anomaly in the demand estimates in the two areas. As has been indicated the take-up level for the Dental Service was expected to be roughly 50 per cent higher than that which had prevailed under NHI. In contrast take-up rates for the Supplementary Ophthalmic service were expected to *the same as* NHI levels. This replicated the practice with respect to the estimates prepared in 1942 which were discussed in the Chapter 3.

The Select Committee did not ask George why this difference in practice occurred. He appeared surprised by the levels of demand for spectacles: 'the actual rush shows that for some reason or other people wanted new spectacles. As they were not very expensive, one would have thought that many people would already have had spectacles of some

sort when the scheme started' (ibid.: qu. 570). Yet the reference to spectacles 'of some sort' pointed to the large market for spectacles purchased without sight testing and, as was indicated above, George had already referred to 'buying them in Woolworths' (ibid.: qu. 606) Furthermore, he had also said that the Supplementary Ophthalmic estimate 'was a very low rate' (ibid.: para. 556). Thus, even if an upward adjustment would have been notional it seems anomalous to have assumed that ophthalmic service take-up rates would be no higher than those under NHI.

Pharmaceutical Costs

When George was asked to give an account of how the pharmaceutical cost estimates for England and Wales were prepared he cited an estimated of £11,450,000 (ibid.: qu. 692). This was based on an assumption of 105 million prescriptions over a nine month period (just over double the level 50 million under National Health Insurance) (ibid.). This was multiplied by an average cost per prescription of two shillings seven and a half pence (13p). This would have given an estimate of £13,650,000 but, again, George assumed lags in the making payments and he thought that seven ninths of demand would be funded in the fiscal year (ibid.; literally this would have given a lower figure of £10.6 million, own calculations). The out-turn figure which George cited was £16,225,000 (ibid.). In discussing the disjuncture he pointed to higher demand as the central factor. The average cost per prescription was very close to the estimate two shillings eight and a half pence (13.5 p) (ibid.: question 693). However demand was stated to be two and a half times the NHI level, unlike the expected doubling (ibid). This would have meant 125 million prescriptions but it is difficult to reconcile this with the cost figures cited by George. Multiplying the prescription figure by the cost per prescription would give

expenditure of £16,875,000 but, if the same assumption about lags were applied then expenditure should have been no more than £13,125,000. However, this issue was not explored in the Committee's questions.

Again the original demand estimate appears to have been based on taking NHI rates and grossing them up for the population to be served under a universal service. Thus it was similar to the wartime estimates of pharmaceutical costs discussed in Chapter 2. Those estimates gave full population cover as roughly 2.2 times the NHI coverage level and the 105 million prescription level cited by George would be 2.1 times his NHI prescription level. As was suggested in Chapter 2 such grossing up left no room for any increase in take-up rates which in turn, could have reflected a backlog of health problems as a legacy from the inter-war period.

Hospitals

With respect to under-estimates of the costs of the Hospital Service it was pointed out in the last section that this was not driven by large variances between estimate and out-turn.

In contrast to the Dental and Ophthalmic areas the under-estimates were modest.

However, hospitals were substantially the most expensive single component of the Service and thus a relatively small variance translated into a significant under-estimate in cash terms as was shown by the data presented in the third section.

The Select Committee were told that the 1948-9 estimates were prepared in the Autumn of 1947 and '...were based on returns from the larger hospitals of their expenditure for the last complete financial year' (Select Committee on Estimates, 1949: xxi). In some cases this referred to the calendar year 1946 and in others to the financial year 1946-7 (ibid.). When he was asked how the hospital estimates had been prepared George stated

‘...we had some information on what voluntary hospitals used to cost from out of date year books, we knew what hospitals belonging to local authorities cost. We did send out and got a return which covered about 90 per cent of hospitals and we had to take these figures for what they were worth and make any estimates from them’ (ibid.: qu. 938).

As was indicated earlier, the lack of documentary sources makes it impossible to investigate what came out of these returns or which year books were used and how. However, this did involve a change in practice with respect to the wartime estimates discussed in Chapter 4. It was argued there that a striking feature of the hospital cost estimates, during that period, was that they did *not* use cost data from sources like the Hospitals Year Book. It would appear that more direct cost data was used in this case, although this cannot be directly verified in the absence of documentary evidence.

Another possible implication of the use of such cost data was a more realistic view of hospital costs. Certainly there was a very substantial increase in the hospitals estimates when contrasted to those given for England and Wales in the 1946 Financial Memorandum. The figure given in the latter was £87 million but the 1948-9 estimate was £107.2 million for the part-year or £144.5 million on an annualised basis. Thus over less than eighteen months the cost estimate, on a comparable annual basis, had increased by 66 per cent.

Even if this cost data gave a more realistic basis for the estimates there were still a number of problems. The data for voluntary hospitals and thus effectively of the teaching hospital sector of the new Service would be based on the honorary consultant appointment system. In contrast under the NHS such posts would be salaried on either a part-time or a full-time basis (Select Committee on Estimates, 1949: qu. 1040). Another

claim which was made was that, knowing that their hospitals would be transferred to a national service the administration of both voluntary and municipal hospitals cut back on maintenance expenditure creating a backlog of work once the NHS came into operation (ibid.: qu. 1045). A further major problem related to pay settlements. The hospitals were a service area in which pay and salary costs played a central role in overall expenditure. A whole series of key pay settlements occurred too late for a realistic view of pay rates which would prevail through in the first year of the Service to be formed. These included Whitley Council decisions on the pay of nurses, technical and ancillary staff some of which were still being decided during the first year of the Service. In addition the Spens Committee on consultants pay did not report until June 1948 (Webster, 1988a: 118).

Overall then there was no single problem behind the under-estimates. At one extreme where an effective pay pool operated with GPs and where the estimate could reflect the pay settlement at the beginning of the Service estimating was unproblematic. At the other the effectively demand led services posed a much more formidable estimating task.

Arguably this was compounded by the technical weaknesses of the Ministry which meant that no attempt was made to use techniques like social surveys to predict demand and that somewhat arbitrary decisions were made on how take-up rates should be adjusted with reference to the NHI experience. With respect to hospitals, although, given the cost of this part of the Service, any error would be significant, the record was, in many respects, a great improvement over the wartime estimates which had been incorporated into the Financial Memorandum. The apparent direct use of cost data and the correlative substantial increase in the 1948-9 estimate as against that of 1946 would seem to have given a much more realistic base for the calculation. There was no one problem of

estimating NHS expenditure but rather a diverse experience across parts of the Service this was even more the case the politics of NHS expenditure over the 1948-51 period. The next section considers how views of the ‘crisis of expenditure’ was related to the political stances of the key players.

Competing Truths: the Politics of NHS Expenditure 1948-1951

As was indicated at the beginning of the Chapter, in this final section key political positions will be distinguished: that of Bevan, the Minister of Health till October 1950; that of the Treasury; and that of Bevan’s Labour critics.

Bevan’s Political Settlement

As was pointed out in the Introduction, the combination of international indebtedness inherited from the Second World War and the post-war fuel and devaluation crises created an unfavourable environment for public spending. Such forces would have increased the pressure on any Minister of Health but to understand the way in which Bevan responded to them it is necessary to understand his politics of NHS expenditure. He looked at the NHS in the context of a socialist politics of health care, seeing the NHS as part of a new social settlement. This conditioned his approach to proposals, stemming both from his Labour critics and from the Treasury, for the use of charges in the Service. Discussing a proposal for hospital charges in a Memorandum to the Cabinet of March 1950, he argued ‘in the hospitals...if we tried to recover a maintenance or “hotel” charge from patients for their keep, we should at once be charging people who would not have had to pay, in some of the hospitals *even in the days before the National Health Service started*’ (National Health Service (England and Wales), Memorandum by the Minister of Health, CP (50) 56, 20th March 1950, PRO, CAB 129/39, my emphasis). This was problematic because the NHS had to represent an advance in terms of access to health

care when contrasted to inter-war provision. Such arguments might seem at variance with Bevan's acceptance of prescription charges in 1949 and critics of his grounds for resignation in 1951 have taxed him with inconsistency in this regard (Donoughue and Jones, 1973: 485; Campbell, 1987: 247). Yet, as was pointed out in the Introduction, Bevan's acquiescence on charges was tactical and he vigorously frustrated their implementation.

Another strand in Bevan's thought extended the conditions of the new settlement to the terms and conditions of employment offered. For example, in a joint memorandum of November 1949, Bevan and Woodburn (then the Secretary of State for Scotland) argued that, while NHS pay determination should be influenced by the Chancellor's pay policy, formulated in September of that year, it still left a number of 'difficult cases'. These included where offers had been made to NHS staff by the management side; where not proceeding with increases would disturb pay relativities, as with nurses; and where certain groups would have a strong case should they go to arbitration (Stabilisation of Salaries and Wages in the National Health Service, Memorandum by the Secretary of State for Scotland and the Minister of Health, CP (49) 220, 1st November 1949, PRO, CAB 129/37). It is fair to add that this did not preclude Bevan arguing for wage restraint. Indeed he took a harder line than Woodburn on this score. Bevan thought that '...all discussions about salaries and wages must be conducted in accordance with the principles it [the Chancellor's statement] sets out' (ibid.). In contrast, Woodburn thought that this was '...bordering on interference with wage-negotiating machinery' and wanted '...the Chancellor's statement introduced into discussions on the Whitley Councils by the...management side in the usual way' (ibid.).

Bevan's support for holding to the broad framework for setting terms and conditions of employment also led to a difference with Gaitskell on the pay of consultants. Gaitskell had submitted a paper, in November 1950 arguing a case for cutting the pay levels of new entrants to consultant grades, *inter alia*, on the grounds that current rates led to 'the wide differentiation, to the advantage of the consultant, between the rates of pay of consultants and those of other public servants' (Committee on the National Health Service, NH 50 (26), 6th November 1950, Consultant's Pay, Memorandum by the Chancellor of the Exchequer, PRO, CAB 134/518).

In his response Bevan disputed Gaitskell's arguments that consultants were treated favourably but he also argued, with respect to the points raised by Gaitskell, that 'they are not new reasons for justifying a reduction in rates fixed less than eighteen months ago', the latter was a reference to the terms agreed, following the Spens recommendations, in July 1949 (Committee on the National Health Service, NH 50 (31), 17th November 1950, Salaries of Consultants, Memorandum by the Minister of Health, PRO, CAB 134/518).

Part of Bevan's politics of health policy was a defence of the NHS as part of a new political settlement but there was also another side to his approach to NHS expenditure. Macnicol (1993: 142) has argued that 'Bevan's attitude to the rising cost of the NHS was ambivalent'. Thus while he 'vigorously defended the principle of a free service' he also 'recognised the political need to assuage his colleagues' fears' (*ibid.*).

The latter objective was pursued in a variety of ways. Bevan was willing to offer expenditure cuts. Thus in his letter to Cripps of 6th January 1949 he detailed a £27.75 million cut in the 1949-50 estimates including a cut in fees for dentists of £11.5 million

(Bevan to Cripps, 6th January 1949, PRO, T 227/185). Abel-Smith and Titmuss estimated that prices of Dental Services under the NHS had fallen by 18.7 per cent between 1948-9 and 1950/1; and the corresponding fall in the Supplementary Ophthalmic service was 13.6 per cent (Abel-Smith and Titmuss, 1956: 40 and 43).

Bevan was also concerned to set expenditure trends at the outset of the Service in the context of the pressures generated by a backlog of demand. He argued that such increases in demand, particularly for Dental and Ophthalmic services would not be a permanent feature of the Service. In a Memorandum of September 1949 he claimed 'already the first flush of people trying to "get all they can while it's free" shows signs of dying down' (Government Expenditure, Memorandum by the Minister of Health, 14th September 1949, PRO, T 227/185); and in a similar vein, in May 1950, he said that 'recent experience suggests that the demand for spectacles has now fallen to a level prevailing before the Act was passed' (NHS (50) 2nd Meeting, 23rd May 1950, PRO, CAB 134/518).

He also stressed the difficulty posed for the early estimates of limitations on the data available. Thus, at a Cabinet meeting in May 1950 he is minuted as wishing '...to draw attention to the difficulties of fitting the new service into the system of annual budgeting during its early formative years' (Cabinet, CM 49 (37), 23rd May 1950, PRO, CAB 21/2035). In this respect he pointed out that Regional Hospital Boards had to submit their estimates for 1949-50 within six weeks of their formation. Bevan appeared to have some success in inserting such issues into the debate on NHS expenditure. Thus Cripps had made a similar point in the Commons debate on the 1949-50 supplementary estimates when he referred to the fact that Hospital Management Committees had been required to submit their 1949-50 estimates to Regional Hospital Boards by the 1st September 1948,

less than two months after the start of the Service (Cripps, Hansard, Parliamentary Debates, House of Commons Debates, Vol. 472, 14th March 1950, Col. 934).

Finally, Bevan was intent on setting expenditure limits in what he saw as a relevant context. This was particularly significant in the fiscal year 1950-1. In his Budget statement Cripps had stated that there was no reason for exceeding the estimates in the next fiscal year and an expenditure ceiling for 1950/1 was agreed (Webster, 1988a: 153). From Bevan's point of view such ceilings were dangerous in the context of what he saw as the necessary uncertainties of the early years of the Service. Thus he sought to create room for manoeuvre. Much of the key debate in this period took place in the Cabinet Committee on the NHS. In a Memorandum to the Committee of May 1950, Bevan argued that the ceiling estimates assumed that prescription charges were to be imposed and this involved a yield of £6 million which would not now arise. In addition he cited a figure of £2-3 million as an effect of inflation on Service costs. Thus he argued 'we are already starting the year with, as it were, an adverse balance of £8 or 9 million, owing to the estimates having allowed for the shilling charge on prescriptions and owing to changes in the cost of living since the estimates were formed' (NH (50) 3, 6th May 1950, Committee on the National Health Service, Questions Arising Out of the New "Ceiling" Policy, Memorandum by the Minister of Health, PRO, CAB 134/518).

Consequently Bevan sought to conceptualise the 'problem' of NHS expenditure as a transitional one influenced by a new set of pay settlements, the backlog of demand and the lack of reliable data for cost estimates. In such a context policies such as charges and reintroduction of means testing were a panic reaction which involved a breach of the principles of the new settlement. His conceptualisation of the issue was, however,

radically different from the outlook of both senior Treasury officials and of Bevan's critics in the Labour Cabinet. The views of these groups thus need to be discussed.

The Treasury

The Treasury's immediate concern was the control of public expenditure and the NHS initially surfaced as a major issue with the supplementary estimates of 1948-9 and 1949-50. However, in their responses to the NHS a clear health politics can be discerned which can be characterised as the obverse of Bevan's. Thus, if Bevan wanted to affirm the importance of a break with inter-war social and health policy, the Treasury wanted to return to that politics.

A central theme in the Treasury approach was the support for the imposition of charges. In one sense this was related to the point raised in the third section that the initial cost over-runs in Dental and Ophthalmic services in particular were driven by demand factors. Thus, in a Memorandum of January 1949, Hale, then an Under-Secretary (British Imperial Calendar and Civil Service List, 1949: 18) argued, with respect to the Dental and Ophthalmic areas, that 'the main reason why the cost of the service is so much higher than was expected is not that the unit of service...is costing more than was expected but the number of units claimed by the public exceeded all expectations' (Hale, National Health Service, 11th January 1949, PRO, T 227/185).

In this respect charges were seen as the key policy tool and Hale went on to claim 'if charges are considered impossible *then the demand for service will continue unchecked*' (ibid., my emphasis). This suggested a quite different view of demand to that put forward by Bevan. Whereas he saw the backlog of demand as the fundamental source of the boost to demand, Hale was arguing was that the fact that the Service was free at the point of use

was the key determinant. However, Hale did not consistently hold this view and in an earlier Memorandum he had remarked ‘...no doubt the rush to get free dentures and spectacles will die away’ (Hale, National Health Service, 16th December 1948, PRO, T 227/1112). Clearly *this* was close to Bevan’s position and suggested that charges were not the only way in which demand might fall.

However, the later Memorandum gave perhaps a more fundamental clue to Hale’s attachment to charges. They appealed not just as a means of checking demand but he stated ‘I think a charge is right. I have never been able to see why people should get dentures and spectacles for nothing any more than houses, food and clothing’ (Hale, National Health Service, 11th January 1949, PRO, T 227/185).

Such hankerings for pre-war practices also figured in the discussion of hospital policy. In part this related to narrower expenditure control issues. Bevan had sought to meet criticisms that the nationalisation of hospitals meant imperative controls from the centre by claiming that he had promoted a high degree of decisional autonomy at Regional, Board of Governor and Hospital Management Committee (HMC) level. As was pointed out Morrison raised the problem of the compatibility of such autonomy with financial control. This also concerned the Treasury. In a memo of June 1950, Hale argued that, if a HMC or Board of Governors overspent on their budget the sanctions which the Region could impose were unlikely to be effective. It would be possible for the Board or Committee to be dismissed but ‘in practice it would be impossible to take such a measure on account of overspending. Public sympathy would be against the Minister...’ (Hale, Financial Control of the Hospital Service, 28th June 1950, PRO, T 227/1113). This led to the proposal that the Secretary and Treasurer of the HMC should be appointed by the

Minister and have the power to oblige the HMC 'seek the approval of the Minister in prescribed circumstances' (ibid.).

However, it is interesting to examine the basis for such Treasury concerns. Given the anxiety over lack of expenditure control it might have been expected that they related to palpable over-spending. Overall variances in the hospital service were not large. Furthermore they were skewed. Thus the figures published in the Select Committee on Estimates report of 1949 showed that, for England the original estimate for non-teaching hospitals was £91 million and the expected out-turn £103 million, in contrast, for teaching hospitals the respective figures were £10 and £18 million (Select Committee on Estimates, 1949: xix). Thus the overall hospital variances were substantially increased by the very large proportional differences between estimates and expenditure in the teaching hospitals. The Treasury was also aware of this contrast. In a discussion of the 1949-50 estimates Hale favourably contrasted the non-teaching with the teaching hospitals and he concluded that there was 'no reason to think that non-teaching hospitals are run otherwise than economically' (Hale, National Health Service England and Wales Estimate 1949-50, 26th November 1948. PRO, T 227/1112). This raised the question as to why, if such hospitals were run 'economically', a change in the structure of financial control was needed. Hale's argument was as follows: 'the Regional Hospital Boards have been recruited from men (sic) accustomed to the old regime, when rate money was hard to come by...the new regime is essentially one of easy money and easy money is almost infinitely demoralising' (ibid.). In the regime of 'easy money' thus what was required was controls which could simulate the controls of the 'old regime'.

There are two other instances of the desire to unpick the NHS settlement which are worth exploring in looking at Treasury views. Hale's commitment to charges in principle meant that he wanted them imposed across the Service. Consequently he supported hospital charges and an extension of the number of pay beds. However, with respect to the latter, he suggested that to get to a significant level of pay beds it could be necessary to give 'some preference (e.g. a shorter waiting list)' for paying patients (Hale to Gilbert, Economy Ministry of Health, 11th November 1949, PRO, T 227/185). Similarly he saw hospital charges and 'preferences' for paying patients as a means to revive the pre-war hospital subscription schemes 'an arrangement under which patients making relatively modest payments for beds received some preference over those who did not might lead to a stimulation of the hospital savings movement and I think it would be a very good thing if it did' (ibid.).

A final manifestation of the Treasury adherence to pre-NHS practice related to the strategy of proposing the abolition of parts of the Service. In January 1949 Gilbert suggested abolishing the Supplementary Ophthalmic service. Again this appeared a thinly disguised desire to unravel the NHS settlement. Gilbert admitted that if this policy was implemented 'there would be a reduction ...in the facilities for eye testing' but he went on to claim that 'most of the real needs have been met in the initial rush' (Gilbert to Bridges and Trend, 12th January 1949, PRO, T 227/185). What is extraordinary here is that this claim was made after the Service had barely operated for six months, it was also unclear how 'need' was to be defined and measured.

The Labour Right

The final position to be considered in the debate on NHS expenditure is that of Bevan's critics in the Labour Cabinet. If Treasury health politics was characterised by a desire to return to the status quo ante Bevan's Labour critics are perhaps best seen as fearful of the effects of Bevan's new settlement. In part this was the other side of the attachment to the gradualism of figures like Morrison.

One interesting manifestation of this approach, which relates back to concerns discussed in Chapter 4, relates to the use of expenditure benchmarks. Two important examples stem from advice given by officials in Morrison's office. Thus, in a comment on trends in NHS expenditure Morrison was advised that 'the cost for 1949/50 is...expected to be more than twice the figure given [to] the public with the Bill (£152 million) (Pimlott to Morrison, National Health Service, 6th January 1949, CAB 21/2035). The significant reference here is to the estimates given in the Financial Memorandum to the National Health Service Bill which is used as the means of judging the trend of increased expenditure from the beginning of the Service in 1948-9. The logic of such a position was that the expenditure trend would appear alarming. Equally it could appear that there needed to be drastic cuts in expenditure. Thus in a discussion of the imposition of a ceiling on NHS expenditure for 1950/1, a figure of £300 million for the UK was suggested. This was a 'net' figure i.e. it involved deducting 'appropriations in aid' such as particularly, the share of national insurance contributions allocated to the funding of the NHS. A £300 million ceiling in net terms involved a radical reduction in expenditure and was virtually one third below the net total (£392 million) which was, eventually, adopted (Webster, 1988a: 135). However, in seeking to justify this figure it was argued

‘this would still give the Health Services well over double the figure (£126 millions) on the basis of which the Government decided to go forward with the Service in 1946’ (Nicholson to Morrison, National Health Service, 11th March 1950, CAB 124/1188; see also Laybourn, 1995: 232). The reference was, again, to the Financial Memorandum as the £126 million was the expected ‘net’ expenditure figure for the UK health services given in that document.

Such arguments suggested that existing levels of expenditure were excessive. Thus Webster reports Cabinet discussions that the £392 million (net) limit for 1950/1 should be reduced to £350 million and Morrison criticised economies suggested by Bevan as offering no prospect of achieving such a target (Webster, 1988a: 155). Similarly Gaitskell, recording a discussion with Cripps in his diary, stated ‘I would have liked this [the ceiling on NHS expenditure] to have been below next year’s estimates so that we should be quietly committed up to the hilt to finding the rest of the money, so far as economies would not cover it by making charges of some kind’ (Williams, 1983: 174).

The reference to charges was another symptom of the Labour critics suspicion of Bevan’s attempt to radically break from past practice. As Webster (1988a: 159) points out a significant weakening in Bevan’s position had occurred with the replacement of Woodburn as Secretary of State for Scotland by McNeil: ‘Woodburn had generally gone along with [Bevan] but McNeil moved away from the principle of a comprehensive and free service. McNeil aligned himself with Morrison...’ (ibid.). Thus an index of the view of the NHS on the Labour right as an experiment that had failed was a letter from McNeil to Morrison of May 1950 where he asserted ‘we can now see that a fully comprehensive service, available without charge to everyone would cost more than the country can

afford' (McNeil to Morrison, 19th May 1950, PRO, CAB 124/1188). Similarly a feature of Labour right policy was the endorsement of a policy of abolition of all but the priority service in the dental and ophthalmic fields a policy supported by Morrison (Webster, 1988: 155), Gaitskell (Williams, 1983: 239) and McNeil (NHS (50), 2nd Meeting, 28th June 1950, CAB 134/518).

Thus suspicion of the new settlement as over ambitious related to support for a more 'gradualist' approach involving charges, tighter expenditure limits and reductions in the scope of the Service. It also engendered an intense distrust of Bevan with the anxiety that the Cabinet had been misled on expected expenditure levels. Thus in a discussion of the impact of pay settlements and higher than anticipated hospital maintenance expenditure it was suggested to Morrison that manipulation may have occurred since 'should not some allowance have been made for these items? Should not the Cabinet have been informed?' (Pimlott to Morrison, National Health Service, 6th January 1949, PRO, CAB 21/2035). Reflecting a similar view of Bevan, Gaitskell recorded in his diary that he found him 'slippery and difficult' (Williams, 1983: 179); and Morrison (1960: 267) no doubt projecting views of his own, stated in his autobiography 'Nye is getting away with murder' was 'the general feeling of my colleagues'. This, in turn led to pressures to control Bevan. Thus, as early as May 1949 it was suggested to Morrison 'may there not be a case for a small but strong Ministerial Committee to review the present and future programmes of the service and report to the Cabinet on possible economies...?' (Pimlott to Morrison, 17th May 1949, PRO, CAB 21/2035).

Three Truths and the Expenditure Trends 1948-51

To conclude this section the three versions of the ‘problem’ of NHS expenditure 1948-51 will be discussed in the context of the evidence on expenditure trends. It should be stressed that this will not be an attempt to adjudicate between the ‘truths’ since the differences involved reflected, as has been argued, not just views of expenditure in this period but also differences on the principles of social and health policy. Three issues will be considered: the legitimacy of claims that Bevan misled the Cabinet over NHS costs and effectively ‘bounced’ colleagues into agreeing to the policy by misrepresenting its public expenditure implications; the extent to which expenditure in the period was ‘out of control’; and, finally, the argument on the impact on the economy of the NHS.

The claim that Bevan misled the Cabinet was discussed by Brook, the Cabinet Secretary, in his letter to Atlee of 29th March 1950 ‘in the recent Cabinet discussions on the National Health Service the suggestion was made that Ministers were not given sufficient early opportunity to consider the mounting costs of this service- and it was implied that the Minister of Health had contrived to keep these matters from being discussed by the Cabinet and any of its Committees’ (Brook to Prime Minister 29th March 1950, PRO, PREM 8/1486). Given the date of the letter the reference is, primarily, to costs after the beginning of the Service. However, in a document *National Health Service (England and Wales)* attached to the letter Brook surveyed the period from January 1946 arguing (in the letter) that the record ‘...does not confirm the suspicion which is entertained by some of his colleagues that the Minister of Health has kept matters from the Cabinet’ (ibid.).

In the document Brook pointed out that, for example, when the Legislation Committee approved the draft of the NHS Bill in March 1946 ‘no financial points of substance were

raised in the Committee's discussion' (ibid.). Equally, as has been indicated, the 1948 hospitals estimate was over 60 per cent above the figure for the Financial Memorandum a figure well above any inflation adjustment. This appears to have raised no comment (e.g. Brook does not refer to any discussion in his chronology) and the substantially increased figure would hardly be consistent with a strategy of manipulation.

This is also confirmed in the Treasury files. There were finance related concerns raised by Treasury officials. However, these were of two kinds: there was anxiety that Bevan's delegation of financial delegation to Hospital Management Committees was inconsistent with the Minister's responsibility to Parliament for health expenditure (see Hale National Health Service 15th December 1945, T 161/1243 and Dalton's annotation endorsing Hale's view). As was indicated earlier the Treasury continued to pursue this issue after the creation of the Service. The other issue was the adjustment of the block grant to local authorities following the transfer of municipal hospital costs to central government and, inter alia, the inter-authority distributional effects (see Gilbert, The National Health Service Bill 6th March 1946 T 161/1243 and Webster 1988a: 87). However, there was no questioning of the overall cost estimates.

Moreover it is worth noting that there was a well attested case of the manipulation of estimates but this was *by Gaitskell*. As Webster (1988a: 172) points out, Bevin, the Foreign Secretary, had suggested to Gaitskell a £400 million (net) expenditure target for the NHS for 1951/2. This suggestion was made in a context in which Gaitskell was seeking support in the Cabinet for Dental and Ophthalmic charges. Bevin was under the impression that the agreed ceiling was £393 million, a figure cited by Gaitskell in a key Cabinet discussion of 22 March 1951 (ibid.). With respect to this Webster points out that

‘Gaitskell’s review of events was significantly in error. The agreed figure was £398 million...Gaitskell realised that his concession would seem more generous if the additional £5 m was kept ‘up my sleeve’ (ibid.: 173, see also Gaitskell’s diary on this point, Williams, 1983: 242).

The second key issue was the extent to which NHS expenditure was ‘out of control’. As has been seen there were a number of problems in the arguments of both the Treasury and Bevan’s Labour critics on this score. With respect to the former it was pointed out that Hale was inconsistent in arguing on one hand that demand in Dental and Ophthalmic services could only be checked by charges but also effectively accepting Bevan’s view that there was a backlog effect. Part of the problem with the debate here was there was excessive reliance on *expenditure* trends. However, in the Dental and Supplementary Ophthalmic services a downward trend in demand would not translate into an immediate fall in expenditure because of the effect of lags between the undertaking of work and payment for that work. Thus Bevan argued, in May 1950, that although demand for spectacles had fallen ‘the provision of spectacles already prescribed would prevent the savings under this head becoming fully apparent until the next financial year’ (NHS (50), 3rd Meeting, 28th June 1950, PRO, CAB 134/518). Equally Ministry of Health officials pointed to the fact that cuts in dental and ophthalmic fees could not take immediate effect because work had been paid for at the rate applying when the treatment started (Mitchell, Select Committee on Estimates, Departmental Reply to the Seventh Report The Administration of the National Health Services, August 1949, PRO, T 227/185).

A more rational debate on this issue could have been advanced if, in addition, to considering financial trends, use was made of physical measures. In this respect it is

interesting to note the evidence presented in Table 5.9 which shows trends for the supplementary ophthalmic service 1948-51.

Table 5.9: Supplementary Ophthalmic Service: England and Wales Trends in Sight Tests, Spectacles Supplied and Service Costs 1948-51.

Year	Sight Tests (million)	Spectacles Supplied (million)	Cost (£ million)
1948-49	5.88	3.47	11.16
1949-50	5.41	7.48	21.73
1950-51	4.86	7.74	19.57

Source: Supplementary Ophthalmic Services (England and Wales) from 5/7/48, PRO, MH 137/80.

As the Table indicates sight testing rates were in continuous decline from the first year of the Service a feature understated in the Table since annualised rates are not used. On the other hand supplies of spectacles in 1949-50 were over double the 1948-9 levels and cost was also virtually double. Clearly merely concentrating on *financial* trends here gives a highly misleading view of demand trends.

There are, equally, problems with the arguments advanced by Bevan's Labour critics. Thus, as was indicated above, the 1946 Financial Memorandum estimate was used as a benchmark and an argument for drastic cuts in expenditure particularly following the supplementary estimates of 1949-50. However, this presupposes that this figures was a reasonable baseline for NHS expenditure. Yet as was argued in the first section, the 1946 estimate carried over the under-estimates of the 1944 White Paper, particularly with respect to hospital expenditure. Furthermore there was no consideration of why the 1948/9 estimates were so much higher than those for 1946,

Finally one of the ironies of the political tensions on the Committee on NHS expenditure and, subsequently, Bevan's resignation was that it came during a period when expenditure was increasingly 'under control', by 1950-1 estimate and out-turn were

in line. Bevan was required to submit a regular report to the NHS Committee on expenditure trends. His last was in November 1950 and is given in Table 5.10.

Table 5.10 Report on NHS Estimates and Expenditure to the Committee on the NHS, 16th November 1950.

Service Area	Expenditure (£)	Estimate (£)	Surplus (£)
Hospitals	120,799,786	129,103,381	8,307,595
Executive Councils	78,284,000	78,320,000	36,000
Other NHS	7,079,009	10,594,442	3,519,433
Local Authority	7,767,538	8,590,000	822,462
Total	213,922,333	226,607,823	12,685,490

Source: PRO, CAB 134/518

While the phasing of payments over the year and pay awards mean that the surplus would not give a completely adequate guide to the full year result there was no need for a supplementary estimate, as the crisis of expenditure was coming to a head expenditure was ‘under control’.

The final issue to be considered is the impact of NHS expenditure on the economy. Given the economic context in which Labour was working it was perhaps not surprising that increased NHS expenditure was seen as damaging to economic growth. Thus it was suggested to Morrison that the NHS was pre-empting resources from ‘other desirable alternatives’ such as ‘...more goods in the shops, capital development, the export drive etc.’ (Pimlott to Morrison, 6th January 1949, PRO, CAB 21/2035). As was pointed out in Chapter 1, such arguments have been restated in the modern historical literature by Corelli Barnett. However, as the argument in that Chapter showed, a convincing case can be made that the demands of the NHS in terms of labour and materials were relatively modest and did not correspond to the substantial opportunity cost implied in the statement quoted above.

Conclusion

In his book *In Place of Fear* Bevan looked back on this period and made the following observation: ‘Those first years of the Service were anxious years for those of who had central responsibility...not because we feared for the principles of the Service, but in case they would not be given time to justify themselves’ (Bevan, 1978: 107). However, he went on to take satisfaction in the fact that ‘it is not generally appreciated that after only one full year’s experience of the Service I was able to put in an estimate which was firm and accurate’ (ibid.).

This view was not, of course, shared by Bevan’s critics. However, the research discussed in this Chapter has illuminated the point that there was not a self-evident ‘problem’ of NHS expenditure. As was pointed out in the analysis of Table 5.7 (p. 198) a spectacular escalation in NHS costs can be constructed if the 1946 Financial Memorandum is taken as the base for the index. In turn the documentary research has shown how this estimate was taken as a benchmark particularly by Herbert Morrison and his advisers. However, a close study of the 1946 estimate showed how it carried over a number of the unrealistic assumptions of the 1944 White Paper. This illustrates the vital role played by expenditure benchmarks.

The research also shows the perils of generalisation on how estimates were constructed. The 1948-9 estimates for the Ophthalmic Service did involve extrapolating from NHI experience but this was not a general pattern. In the case of hospitals an attempt, in the 1948-9 estimates, was made to use current data although, unfortunately lack of documentary evidence does not allow for the use of such data to be analysed. Chapter 5 demonstrates how the ‘problem’ of NHS expenditure was constructed under Labour

governments. Chapter 6 continues the analysis by looking at how NHS expenditure was conceptualised under the Conservatives, a party with a much more ambivalent view of the expansion of the role of the state after the Second World War.

Chapter Six: A Decade of Parsimony: NHS Expenditure and the Politics of Conservative Social Policy 1951-1960

Introduction

In October 1951 the Conservatives returned to power. This was potentially significant for the resourcing of the National Health Service (NHS) since it involved the replacement of a government ideologically committed to the welfare state with one which saw public expenditure as inimical of some of its key objectives. The 1951 Manifesto promised that ‘a Conservative government will cut out all unnecessary Government expenditure and prune waste and extravagance in every department’ (Craig, 1975: 144).

Conservative health policy in the 1950s could thus be seen as reflecting a *general* imperative to restrain public spending. However, in one important respect seeing constraints on health expenditure as reflecting such a general approach to public expenditure can be misleading. This is because health, in the 1950s, was treated less favourably than other services (Webster, 1996: 7). This suggests that while general pressures to restrain welfare expenditure were significant, there were forces which made the resistance to pressures by the Ministry of Health more difficult and less effective.

There is a further key strand in the politics of NHS expenditure in the period and this relates to the conceptualisation of NHS costs. As was pointed out in Chapter 5, the ‘problem’ of NHS expenditure in the period from the beginning of the Service to the end of Labour’s period in office in 1951 was focused on the relationship between expenditure estimates and out-turns. However, by the mid 1950s, an alternative way of conceptualising NHS cost trends had emerged which had important political consequences.

As was pointed out in the Introduction, Abel-Smith and Titmuss's research crucially informed the findings of the Guillebaud Report of 1956 which, in turn, undercut the arguments of critics of the Service (Jones, 1992: 330). However, it was also argued that Guillebaud was, in some respects, a pyrrhic victory for the Service because pressures to restrain both current and capital expenditure continued *after* the publication of the Report. The object of this Chapter is to examine why, notwithstanding its impact, Guillebaud did not result in a shift away from the regime of rigorous expenditure control in the Service. Two broad theses are advanced: that, while Abel-Smith and Titmuss's methods and the Guillebaud conclusions did give the Ministry new weapons to argue a case for increased spending, these were consistently resisted by the Treasury which retained the NHS expenditure 'problem definition' of the early years of the Service. However, Treasury hostility to social welfare expenditure applied *across* the social services. Thus the second axis of the argument is to seek to account for the failure of health to successfully compete for resources. As will be shown, the character of this competition varied in different periods. However, the Ministry was never able to establish a situation where health was treated as a high expenditure priority. This, it will be argued, was because other services were regarded as more central to the objectives of Conservative social policy in this period.

The Chapter is divided into six parts: the first examines the circumstances surrounding the appointment of the Guillebaud Committee and the impact of Abel-Smith and Titmuss's work on its findings. The second looks at the Treasury's response to the Report and to attempts by the Ministry of Health to utilise the Abel-Smith and Titmuss methodology, to support the case for increased expenditure on health. The third section

examines the patterns of public expenditure across four key social services, health, social security, housing and education over the period. This documents the low priority given to health spending relative to other social services. The fourth, fifth and sixth sections look at expenditure and policy developments in, respectively, housing, social security and education to account, in the relevant sub-periods, for the priority given to these areas. A conclusion seeks to show how the ‘problem’ of NHS expenditure was conceptualised under the Conservatives in the 1950s.

The Guillebaud Committee and the Reconceptualisation of the Costs of the National Health Service

The Guillebaud Remit

The aim of this section is to show how, via the conduit of the Guillebaud Committee, a distinctive conceptualisation of the costs of the NHS emerged to influence the political debate. Pressure for an inquiry into the NHS stemmed from the failure to effect substantial expenditure cuts in the first year after the Conservatives had returned to power in 1951. The proposal to establish the Committee was raised at the Cabinet in February 1953 (PRO, CAB 128/26 CC (53), 6th Meeting). However, at a later Cabinet, Thorneycroft, then President of the Board of Trade, raised his concern as to whether the proposed terms of reference, ‘made it sufficiently clear that the task of the Committee was to find means of reducing the cost of this Service’ (PRO, CAB 128/26, CC (53), 11th Meeting, 12th February 1953). As a result it was decided that the final Committee remit would be determined by the Chancellor (Butler) ‘in consultation’ with Thorneycroft and the health ministers (Macleod and the Secretary of State for Scotland, Stuart) (ibid.).

These consultations revealed important political differences. The aim of focusing the Committee on expenditure reductions was seen as politically dangerous by Macleod who

argued, in a letter to Stuart, that any such reference could lend itself to ‘political misrepresentation’ and ‘that it will be argued that we intend to make “cuts” at all costs in the Health Service and that is our primary concern’ (Macleod to Stuart, 9th February 1953, PRO, T 227/333). In contrast Thorneycroft, when he sent his proposed terms of reference to the Committee to Butler, included the suggestion that, as well as reviewing current and future costs, it should ‘advise how the charge on the Exchequer can be limited’ (Thorneycroft, Enquiry Into the Cost of the National Health Service, Suggested Amended Terms of Reference for the Committee of Inquiry, sent to Butler, 12th February 1953, PRO, T227/333).

Thorneycroft’s suggestion meant substituting the request for advice on ‘how the charge on the Exchequer can be limited’ for the earlier formulation ‘how a rising Exchequer charge can be avoided’. However, Butler shared Macleod’s political anxieties and he told Thorneycroft ‘...I am afraid that if in the terms of reference we use words like “limitation” or “reduction” we shall be in for major political trouble’ and the Committee’s work could be represented as ‘an attack on one of the social services’ (Butler to Thorneycroft, 17th February 1953, PRO, T 227/333). As a result the reference to advising on how to prevent a ‘rising charge’ was included in the final remit (Cmd. 9633: 2). Thus the remit was a defeat for the economic liberals represented by Thorneycroft.

The Committee adopted what Webster (1988a: 206) calls ‘a liberal interpretation of its remit’. Thus, at the first meeting the terms of reference to review present and prospective cost were seen, by Guillebaud himself, as including the cost of the NHS ‘to the national budget’ but also ‘perhaps the wider framework of selected foreign countries, their health

schemes and their national income' (Committee of Enquiry into the Cost of the National Health Service, GC (53), 1st Meeting, 13th May 1953, PRO, MH 137/26). The comparative study was not undertaken but the reference to setting health expenditure in the context of national income (see below) bulked large in the findings of the Committee.

Rethinking Cost Trends

In the Chapter 5 it was pointed out that concerns over NHS expenditure in the first two fiscal years of the Service regularly involved contrasting current expenditure levels with a benchmark derived from early estimates. However, the Guillebaud Report embodied a quite different conceptualisation of the cost of the NHS and the crucial influence here was Abel-Smith and Titmuss's work. At the first meeting of the Committee it was pointed out that 'the National Institute of Economic and Social Research would be glad to aid the Committee on statistical matters' (Committee of Enquiry into the Cost of the National Health Service, GC (53), 1st Meeting, 13th May 1953, PRO, MH 137/26). Abel-Smith, then working at the National Institute, undertook the research for the memorandum with Titmuss acting as 'consultant' (Webster, 1988a: 207). The influence of this work on the Committee's findings can be documented by looking at the sources of the statistical data on NHS expenditure trends in the Report. Forty four statistical tables on various aspects of such trends are derived from the Abel-Smith and Titmuss source (Cmd. 9663; Abel-Smith and Titmuss, 1956).

The result of Abel-Smith and Titmuss's analysis will be discussed below but it is important to investigate the approach to Service costs which they applied and how this differed from the early expenditure benchmarks. In an article which examined, inter alia, trends in social services expenditure in Britain in the 1950s Hagenbuch (1958: 2)

described the Abel-Smith and Titmuss study as the first attempt to apply ‘the modern technique of social accounting’ to the discussion of social service expenditure. He saw this as an approach which was being broadly applied and referred (ibid.) to a further application in Vaizey’s (1958) book *The Costs of Education*. An examination of Abel-Smith and Titmuss’s work, with some comparison to Vaizey, will illustrate how ‘social accounting’ was distinctive from the standards regularly used in the ‘crisis of expenditure’.

An important difference related to how costs were defined. Abel-Smith and Titmuss measured costs ‘in terms of the use of current productive resources’ (ibid: 12). This meant that some costs which would enter the Civil Estimates would be excluded by the Abel-Smith and Titmuss definition because they led to no ‘current benefit’ accruing to the NHS (ibid.:11). For example, payment of the debts of voluntary hospitals taken into the Service would fall under this heading since, unlike, for example, wages and salaries to doctors and nurses, they generated no *current* health service provision (see also Appendix 1). In a similar vein Vaizey’s analysis of education expenditure focused on that which generated educational service provision (e.g. on teacher’s pay, books and stationery) but excluded transfer payments such as grants to students (Vaizey, 1958: 68). These distinctions were not made in the Civil Estimates which included cash payments which were not necessarily linked to Service provision.

In addition there was an attempt to allocate costs to their appropriate fiscal year. For example, the 1952 Danckwerts award to General Practitioners, referred to above, included back pay which, according to Abel-Smith and Titmuss’s approach, should not be allocated to a single year (as in a parliamentary vote) but assigned to the relevant fiscal

year. The result would, in such cases, lead to a smoothing of the trend. Thus, Abel-Smith and Titmuss's net cost figures (i.e. after deducting charges) show an £8 million (1.9 per cent) increase in expenditure between 1951/2 and 1952/3, when the Danckwerts settlement came into effect (ibid.: 24). In contrast the net total of the parliamentary vote (again with charges deducted from the gross figure) showed an increase of £35.7 million or 10.2 per cent since the latter included the *total* cost of the settlement (including back pay) (ibid.).

A distinction was also made in 'social accounting' between current and capital expenditure (see Appendix 1) with the former being defined as yielding benefits within a particular accounting period and the latter yielding benefits 'after the end of the accounting period' (ibid.: 13). The limitations of the NHS accounting data meant that this distinction could not be made as rigorously as the authors might have wished (ibid.). However, there were a number of arguments for making it. In particular capital expenditure could be 'lumpy' reflecting substantial programmes in certain years (ibid.: 13). This, again, differed from the use of expenditure benchmarks in Chapter 5 since, if analysis focused on *overall* expenditure, then the relative effects on expenditure trends of variations in capital as against current expenditure are not signalled (though it is fair to say that, given the very low level of NHS capital expenditure, discussed below, this was not a significant factor in the analysis of cost trends in this period).

The focus in 'social accounting' on resources used for productive purposes engendered another rationale for making a capital/current distinction. Concerns over NHS expenditure related to claims that alternative resource use was being pre-empted by expenditure on the Service. However any economic analysis of this question needed to

reflect the different denominators appropriate respectively to current and capital expenditure. Thus Abel-Smith and Titmuss argued ‘we relate current expenditure to the national income and capital expenditure to total capital expenditure in the economy’ (ibid.). Thus such a distinction meant that capital expenditure on the Service could be set in the context of measures of overall capital expenditure in the economy.

Equally, relating current expenditure to national income meant that a measure of the share of the resources used by the Service could be given. This had another important practical implication. Where there was growth in national income increased expenditure on a given social service could be consistent with a constant or even declining share of national income. The results of Abel-Smith and Titmuss’s analysis in this respect are presented below but the impact of this approach can also be seen in Vaizey’s work. He showed that, while education expenditure increased by 51 per cent from 1950 to 1955, the share of national income accounted for by education increased only marginally from 2.7 per cent to 2.8 per cent (Vaizey, 1958: 76). Thus, whereas criticisms of the NHS as seriously pre-empting alternative resource use, such as those outlined in the Chapter 5, were reliant on impressionistic examples, ‘social accounting’ allowed for a quantification of the share of Service expenditure in national income.

The final key difference in the approaches relates to the adjustment of expenditure trends in the light of price changes. This allowed for a discussion of the extent to which increases in expenditure on the Service reflected price changes or how far they reflected increases in the ‘volume’ of services. Abel-Smith and Titmuss argued that the construction of price indices were essential because it was necessary ‘to analyse the

change in expenditure between...changes in the quantity of goods and services bought and...changes in their prices' (Abel-Smith and Titmuss, 1956: 85).

This, in turn, required an attempt to create price indices for the Service. With respect to current expenditure on the Service this was attempted in Appendix B of the book. Thus, for example, pay of nurses and midwives was analysed in terms of trends in remuneration for five grades and an index for this group was constructed by using a weighting related to the employment of each grade in the Service (*ibid.*: 89; see Vaizey, Appendices B and C for parallel calculations on education).

The construction of such indices was not unproblematic. Thus, for example, on pharmaceutical costs Abel-Smith and Titmuss (*ibid.*: 87) pointed out that marked changes in the composition of drugs used raised the difficulty of using constant weights to construct an index. Equally, no overall index was available for drugs and dressings which meant that a Ministry of Health index of basic drug costs had to be used but this excluded prescription ingredients other than such basic drugs (*ibid.*: 129).

However, while such price indices raised difficulties they did allow for an expenditure series in constant prices which meant that the effects of inflation on Service expenditure could be quantified. It is, of course, the case that debates on expenditure during the 'crisis' period of the first two fiscal years involved an awareness that inflation was a factor in expenditure increases but what was distinctive about the 'social accounting' approach was the presentation of a 'bottom line' expenditure series in constant prices.

Thus, social accounting represented a radically different way of analysing expenditure trends. Expenditure was classified into types with a focus on resources used for service provision; capital and current expenditure were distinguished and related to their

respective denominators; specific price indices were created and expenditure trends presented in constant prices. It is now necessary to examine the results of this methodology in terms of the analysis of NHS expenditure trends produced by Abel-Smith and Titmuss.

Arguably, the aspects of the Abel-Smith and Titmuss method which had most impact on the conclusions of the Guillebaud Report were the adjustments for inflation, the relating of current expenditure to national income and of capital expenditure to gross fixed capital formation. In the case of the latter expenditure on new fixed assets was distinguished from changes in stock values. The key data on trends in these areas is presented in Tables 6.1, 6.2 and 6.3.

Table 6.1 Current Gross Cost of the National Health Service (i.e. before deduction of charges) in actual and 1948/9 prices, England and Wales 1949-9 to 1953/4, £ million.

	1948/9*	1949/50	1950/1	1951/2	1952/3	1953/4
Actual Prices	333.2	376.6	395.7	411.7	436.7	453.4
1948/9 Prices	333.2	374.3	393.1	383.6	391.9	406.4

*1948/9 Figure annualised
Source: Abel-Smith and Titmuss (1956)

Table 6.2 Current Gross Cost of the National Health Service (i.e. before deduction of charges) as a proportion of Gross National Product (GNP), England and Wales 1949-50 to 1953/4: GNP and Gross Cost in £ million, actual prices.

	1948/9*	1949/50	1950/1	1951/2	1952/3	1953/4
(1) GNP	9,349	9,907	10,539	11,560	12,487	13,273
(2) NHS Gross Cost	333.2	376.6	395.7	411.7	436.7	453.4
(2) as % of (1)	3.57	3.80	3.75	3.56	3.50	3.42

*1948/9 Figure annualised

Source: Abel-Smith and Titmuss (1956)

Table 6.3 The Cost of New Fixed Assets (NFA) in National Health Service as a proportion of Gross Fixed Capital Formation (GFCF)*, England and Wales 1949-9 to 1953/4; NFA and GFCF actual prices, £ million.

	1948/9**	1949/50	1950/1	1951/2	1952/3	1953/4
(1) GFCF	1295	1419	1532	1689	1874	2084
(2) NFA	10.4	11.8	11.6	12.5	11.9	11.1
(2) as % of (1)	0.80	0.83	0.76	0.74	0.64	0.53

* GFCF figure 89 per cent of the Great Britain figure.

**1948/9 Figure annualised

Source: Abel-Smith and Titmuss (1956)

Table 6.1 shows that whereas, in actual prices, the current gross cost of the NHS rose 20.4 per cent between 1949-50 and 1953-4; in constant prices the increase was only 8.6 per cent. Table 6.2 indicates a continual decline in gross cost as a percentage of GNP from 1949-50 to 1953-4; and expenditure on new fixed assets in the NHS represented consistently less than 1 per cent of gross fixed capital formation throughout the period and the share was falling sharply over the period 1949/50 to 1953/4.

Not surprisingly this data exerted a powerful influence. The Guillebaud Report endorsed the Abel-Smith and Titmuss methodology arguing that ‘the definitions of “cost” adopted

by the authors seems to us...the right one in that it brings out the amount of the country's real resources which are being absorbed by the National Health Service...and which could be available for other uses'. (Cmd. 9663: para. 11). Equally, not only did the Committee conclude that there had not been 'an increase in vast proportions' (ibid.: para. 23) in the resources allocated to the NHS but it also noted the significance of trends in health spending relative to national income: 'it may come as a surprise to many to find that the National Health Service has absorbed a decreasing proportion of the country's resources since 1949-50...the first full year of the Service' (ibid.: para. 20).

This sanguine account of NHS expenditure trends was linked to the principal conclusions of the Report that the Committee could not recommend any means which would 'reduce in a substantial degree the annual cost of the Service' (ibid.: paras 720-1); nor could it suggest significant 'new sources of income' (ibid.). Indeed, in one significant area the Committee suggested a substantial *increase* in expenditure, on NHS capital investment. This issue will be discussed in detail in Chapter 7 but Guillebaud's recommendation can be related not only to the low levels of capital expenditure from the first year of the Service to 1953/4 but also to a striking estimate, by Abel-Smith and Titmuss, that capital expenditure on the NHS was running at roughly one third of the level prevailing at the end of the inter-war period (Abel-Smith and Titmuss, 1956: Appendix G). Thus the outcome of the work of the Committee was an analysis of NHS expenditure trends and a set of policy prescriptions diametrically opposed to the Treasury view. In the next section the reactions to the report in the Treasury will be analysed.

After Guillebaud: the Persistence of ‘Economy’

As was noted in the Introduction tight constraints on NHS expenditure were a characteristic of the whole of the 1950s. This means, of course, that, notwithstanding the favourable conclusions of the Guillebaud Report, substantially increased expenditure on the Service did not result. In discussing some of the reasons for this the Introduction referred to Webster’s (1996: 6) comment that, in this period ‘the NHS struggled along in an atmosphere of suspicion in government quarters’ and that one of the ‘foundations’ for this suspicion ‘were the unrealistically low speculative estimates for the cost of the new Service made before its inception’ (ibid.). What is particularly important here is the implication that the work of Abel-Smith and Titmuss and of the Guillebaud Committee did not fundamentally shift approaches to how NHS expenditure was conceptualised or discussed. In this section evidence is presented which confirms this view even though there were attempts, by the Ministry of Health (see for example, Webster, 1988a: 215) to use the methodology adopted by Abel-Smith and Titmuss to make a case for the commitment of additional resources to the Service. A constant factor was the resistance of the Treasury to this reconceptualisation.

The fact that the reconceptualisation opened opportunities for a stronger case for higher health expenditure is illustrated in a Memorandum to the Cabinet, in January 1957, from the Minister of Health, Vosper. This Memorandum was written at time when there was pressure for a round of expenditure cuts and Vosper, while he accepted the general case for such reductions, sought to utilise data relating NHS current expenditure to national income; and capital expenditure to overall capital investment in the economy. He summarised the data as follows: ‘the proportion of Gross National Product absorbed by

the Exchequer cost of the National Health Service has fallen from 3.26 per cent in 1949-50 to 2.80 in 1955-56. During the same period the percentage of total investment devoted to capital expenditure on the Service dropped from 0.83 per cent to 0.56 per cent' (National Health Service, Memorandum by the Minister of Health, PRO, CAB 129/85 C (57), 30th January 1957)). While Vosper's figures for current expenditure excluded appropriations in aid (principally from national insurance) this did not involve a distortion to the expenditure trends since the percentage of total NHS funding from insurance was falling during the period covered by his figures (see Webster, 1996: 806).

Disappointed Men

If, however, Abel-Smith and Titmuss's social accounting methodology was beginning to exert an influence over the presentation of the Ministry of Health case the reaction in the Treasury remained unsympathetic. Here the Report was received in an atmosphere of 'the wormwood and the gall'. Thus Turnbull, an Under-Secretary writing to Brittain, a Third Secretary (British Imperial Calendar and Civil Service List, 1955) observed vis a vis Guillebaud 'from a Treasury point of view this is a highly disappointing and indeed unsatisfactory document' (Turnbull to Brittain, Guillebaud Report, 22nd November 1955, PRO, T 227/424). Turnbull's objections covered the lack of recommendations for expenditure cuts or for the raising of new sources of income and the proposed increase in capital spending (ibid.). Brittain concurred and his written annotation to the letter included the observation 'this is pretty awful!' (ibid.; Peden, 2000: 506) In the same vein Workman, a Principal (British Imperial Calendar and Civil Service List, 1955) complained, in a letter to Turnbull, that 'there was no-one to give evidence...saying that the Service was more than adequate or that more income ought to be collected'

(Workman to Turnbull, Guillebaud Report, 28th November 1955, PRO, T 227/424).

Treasury critics were thus concerned because the Guillebaud Report did not confirm their preconceptions regarding scope for expenditure reductions and higher charges. However, what is not present is an intellectual engagement with the Abel-Smith and Titmuss methodological approach. What officials did attempt to do was to undermine the Guillebaud conclusions but these attempts also revealed a pattern of dogmatism and incompetence in handling the relevant data. Thus Workman wrote to Jarratt, a Principal, (British Imperial Calendar and Civil Service List, 1955) regarding the question of NHS capital expenditure asking for advice on whether the statistical evidence supporting an increase in such expenditure ‘could be undermined in any way by saying that other social services as well as the hospital service had to suffer in favour of defence’ (Workman to Jarratt, Hospital Investment, 5th December 1955, PRO, T 227/424).

Jarratt passed the inquiry on to Paine of the Central Statistical Office whose response was definitive. He told Jarratt ‘Workman hasn’t a chance of making anything of his suggestion in the penultimate paragraph [reproduced above]’ (Paine to Jarratt Hospital Investment, 6th December 1955, PRO, T227/424). In part the problem related to Workman’s misconception that expenditure on weapons was treated as capital expenditure in the national income accounts whereas they were treated as *current* expenditure (ibid.). However, Paine also included a comparison of capital investment in housing, education and health (reproduced as Table 6.4), the pattern was clear, capital investment was both falling in health and treated less favourably than other social services.

Table 6.4 Share of Social Service Programmes and Defence in Total Gross Fixed Capital Formation (percentages), United Kingdom 1950-1954

	1950	1951	1952	1953	1954
Defence	1.7	3.1	4.3	4.2	2.8
Housing	15.9	15.7	17.3	17.6	15.3
Education	2.9	3.3	3.5	3.1	3.0
Health	1.0	1.0	0.8	0.7	0.7

Source: Paine to Jarratt Hospital Investment, 6th December 1955, PRO, T227/424)

Thus Jarratt responded to Workman (8th December 1955, PRO, T 227/424) ‘there is no disguising that hospital investment has slipped behind badly not only vis a vis total investment but also other service investment’.

However, the weak and tendentious character of such Treasury arguments did not mean that pressures for expenditure control relented. Thus, for example, Macmillan (then Chancellor) wrote to Turton (Minister of Health) in January 1956, when the Guillebaud findings had already been made available to Ministers and officials, that ‘hospitals could not be exempt’ from a proposed set of expenditure cuts (Macmillan to Turton, 18th January 1956, PRO, T 227/424).

Treasury thinking also did not assimilate the alternative approach to conceptualising and measuring NHS expenditure developed in Abel-Smith and Titmuss’s work. In a draft statement for the Chancellor (Thorneycroft) of February 1957, fifteen months after the Guillebaud Report had been available to officials and ministers, the familiar expenditure benchmarks of the early estimates contrasted with expenditure out-turns continued to characterise the Treasury approach to NHS expenditure trends: ‘we have given anxious consideration to the growing cost of the National Health Service. When it was established it was expected to cost [total] £175m a year. By 1949/50 the cost had risen to £450 m...in 1957/8 the gross cost of the Service will be £690m’ (Unsigned, Draft Statement on

Estimates, 19th February 1957, PRO, T 227/485), the £175 million was a reference to the Financial Memorandum gross expenditure estimate for Great Britain. For the Treasury it was a case of ‘ils n’ont rien appris, ni rien oublié’.

Losing Out? NHS Expenditure in the Context of Social Services Expenditure 1951-1960.

In the last section the aim was to show that Abel-Smith and Titmuss’s innovations in the discussion of NHS expenditure trends did not shift Treasury suspicion of the Service.

However, while this was important in sustaining economy drives it is also the case that the Treasury was suspicious of *all* social service expenditure in this period. Thus Bridgen and Lowe (1998: 12) refer to Treasury ‘hostility to welfare expenditure’ on grounds that ‘it consumed scarce resources; it was inflationary...and it created vested interests committed to high expenditure’. As will be demonstrated in later sections, this generalised hostility to social welfare expenditure can be traced with respect to housing, social security and education in addition to health. However, as was pointed Chapter 1, health failed to compete with the other major social services programmes in the battle for resources. This implies that, in other areas, political support for increased expenditure was crucial in over-riding Treasury objections. In turn this suggests that there were compelling policy arguments for giving priority to other services.

Webster (1996) has pointed to a number of key political disadvantages of the Ministry of Health in the 1950s. In January 1951 the housing function was split from health which, he argues, ‘affected morale within the department and reduced its capacity for creative leadership’ (ibid,: 4). This also led to the NHS being ‘relatively unattractive as a proposition for a civil service career’ (ibid.).

In addition to the difficulty in attracting more able civil servants the political status of the Ministry was problematic. Under the Conservatives, from their return to power in October 1951 to July 1962, the Minister of Health was in the Cabinet only for the period, from Oct 1951 to May 1952 (Bridgen and Lowe, 1998: 278). Even in this period, when Crookshank was Minister, he combined the post with that of Leader of the House. This severely limited the time he devoted to health matters (Jones, 1992) and his economic liberal views tended to make him supportive of 'economy' measures.

However, while these features all point to problems for the Ministry of Health in advancing its case for resources they also raise a question as to why health occupied such a low political status. This issue will be taken up in the next three sections which explore the place of housing, social security and education in the context of the politics of Conservative social policy. However, before looking at these service areas it is necessary to examine the expenditure trends across these services.

The trends are outlined in Table 6.5 which gives the expenditure figures from the second volume of Webster's official history of the NHS (Webster, 1996) and presents indices for both the overall trends and those in particular service areas. While data for personal social services is included the discussion focuses on the four largest programmes, social security, health, education and housing.

There are a number of interesting features revealed by the Table. The relative parsimony applied to health is shown by the fact that not only does it 'under perform' the index taking the period as a whole but this is a consistent pattern in each year. In contrast, while housing expenditure at the end of the period lags well behind the overall index there is an important sub-period in fiscal years 1952/3 and 53/4 where expenditure rises sharply. In

the case of social security there is the obverse to the situation in health with consistent 'over performing' relative to the overall index but some particularly marked increases

Table 6.5 Social Service Expenditure Trends, United Kingdom 1951-2 to 1959-60, expenditure in £ million, actual prices (indices in brackets, 1951=100).

Year	Education	Health	Personal Social Services	Social Security	Housing	Total
1951/2	416.1 (100)	493.9 (100)	105.7 (100)	701.7 (100)	417.3 (100)	2134.7 (100)
1952/3	449.0 (107.9)	497.7 (100.8)	119.8 (113.3)	844.8 (120.4)	504.8 (120.9)	2416.1 (113.2)
1953/4	472.3 (113.5)	508.9 (103.0)	118.6 (112.2)	888.2 (126.1)	544.0 (130.4)	2532.5 (118.6)
1954/5	517.7 (124.4)	537.0 (108.7)	120.1 (113.6)	914.1 (130.2)	525.9 (126.0)	2614.8 (122.5)
1955/6	567.4 (136.4)	583.1 (118.1)	129.4 (122.4)	1020.3 (145.4)	501.6 (120.2)	2801.8 (131.2)
1956/7	671.3 (161.3)	639.2 (129.4)	142.7 (135.0)	1067.7 (152.1)	490.0 (117.4)	3010.9 (141.0)
1957/8	756.8 (181.9)	684.7 (138.6)	132.6 (125.4)	1151.4 (164.1)	446.6 (107.0)	3172.1 (148.6)
1958/9	810.4 (194.8)	731.6 (148.1)	136.1 (128.8)	1387.1 (197.6)	412.7 (98.9)	3477.9 (162.9)
1959/60	882.3 (212.0)	787.7 (159.5)	144.9 (137.1)	1458.2 (207.8)	445.2 (106.7)	3718.1 (174.2)

Source: Webster (1996)

e.g. 1954/5 to 55/6 and 57/8 to 58/9. The education pattern effectively is an inverted version of that in housing. In the period of the 'boom' in housing expenditure education expenditure was tightly controlled. In contrast in the mid to late 50s education substantially 'over performs' the index. Before taking the first 'competing' area, housing, it is worth making the point that expenditure on education and housing derived a substantial amount of funding from local taxation. This contrasts with social security which was entirely central government funded and health where the local authority expenditure was a small portion of overall expenditure. In the analysis in the next three

sections, however, the focus will be on politics at a central government level and hence the account is necessarily incomplete. However, this can be defended on the basis that even in the two services deriving a substantial amount of funding from local sources, central government played a crucial role in providing subsidies, grant and regulating provision. Thus, for example, in the period 1951-59 the percentage of local education authority expenditure met from rates never exceeded forty per cent (Central Statistical Office, 1961: 91) and, as will be demonstrated in the next section, housing provision was crucially influenced by central government funding.

Housing: Targets and Residualisation

The Numbers Game

As was indicated in the last section, housing expenditure in the 1950s was characterised by a marked increase during the first three years of the 1951-5 government followed by a decline in spending so that, in nominal terms, expenditure at the end of the decade was only eight per cent higher than in 1951/2. The 'boom' period was significant for health expenditure partly because of the overall financial commitment to housing but also, particularly, that, as a capital led programme, and in a context of material and related shortages of foreign exchange, it put further pressure on the health capital programme.

To account for this pattern it is necessary to analyse the reasons for early sharp expansion in housing expenditure. Two key background issues are central here. The first is that, while the provision of public sector housing was a local government function, levels and type of building were heavily influenced by the extent and pattern of subsidy provided by central government. In the post war period, up to 1956 (Malpass, 1990: 92) this central government subsidy operated in tandem with an obligatory subsidy to the

local authority Housing Revenue Account from the rates or the Rate Fund Contribution (RFC). Central government could thus encourage building via subsidies from the centre and obligatory local subsidies.

The second key issue was the post-war housing shortage. This derived from a combination of population growth and the disproportionate growth in households; between 1921 and 1951 the population of England and Wales increased from 38 million to 44 million (15.8 per cent) but numbers of households increased from 8.7 million to 13.1 million (50.6 per cent) (Land et al., 1992: 69). On the supply side the 'blitz' destroyed 200,000 houses completely and damaged 3.5 million of which 250,000 were uninhabitable (Merrett, 1979: 236); and, as a function of the demands of 'total war' house building virtually ceased, as can be seen from the figures for 1940-5 in Table 6.6.

Table 6.6 Permanent Houses Completed: United Kingdom 1934-1960 (number).

Year	Total	Local Authorities	Private Owners*	Other*
1934-8 Average	361,142	85,945	275,197	
1939	221,758	69,739	152,019	
1940	57,104	26,282	30,822	
1941-4 Average	11,255	5,589	5,666	
1945	3,095	1,936	1,099	60
1946	55,979	25,245	30,566	168
1947	140,885	98,028	41,487	1,370
1948	232,463	193,548	34,390	4,525
1949	205,257	170,806	28,457	5,994
1950	205,427	167,917	30,240	7,270
1951	201,856	166,483	25,485	9,888
1952	248,319	199,177	36,670	12,472
1953	326,804	244,196	64,867	17,021
1954	354,129	239,318	92,423	22,388
1955	324,423	196,024	116,093	12,306
1956	307,674	170,710	126,431	10,533
1957	307,590	169,629	128,784	9,177
1958	276,633	143,283	130,220	5,130
1959	281,568	124,545	153,166	3,857
1960	304,255	128,216	171,405	4,634

Source: Central Statistical Office (1961) *figures before 1945 private and 'other'

Housing shortages were reflected in the political salience of housing. Thus a Gallop Poll of 11th June 1945 asked what electors thought was the main election issue. 41 per cent chose housing as against 15 per cent full employment and, notwithstanding the significance of the Beveridge Report, 7 per cent social security (McCallum and Readman, 1947: 237).

Bevan, when he became Minister of Health also took responsibility for housing and to understand subsequent Conservative policy it is necessary to review his approach to housing policy. In a speech in the House of Commons on the 17th October 1945 he pointed out that in pre-war housing policy 'local authorities were confined largely to

slum clearance schemes' leaving general needs housing to private enterprise (Bevan, Hansard, Commons, Parliamentary Debates, Vol. 414, 17th October 1945, col. 1222). He went on to argue that this created 'grave civil damage' since 'you have colonies of low-income people living in houses provided by local authorities, and you have the higher income groups living in their own colonies' (ibid.). The logic of his position was a resolute opposition to any residual role for local authority housing. This meant not only that local authorities were to take a dominant role in provision (see the 1946-51 figures in Table 6.6) but also that local authority properties were to be built to a high standard. The wartime Dudley Report had recommended an increase in the size of local authority houses to 900 square feet plus 70-100 square feet of external storage (Malpass, 1990: 76-7). This contrasted with a pattern of provision, in the inter-war period, where most local authority houses were less than 800 square feet (ibid.: 76). These standards were embodied in the Housing Manual and Table 6.7 shows how provision of living space increased markedly under the immediate post-war programme.

Table 6.7 Average Floor Area of Five Bedspace (Local Authority) Dwellings in Approved Tenders in England and Wales 1939-1960

Year	Floor Area (Square Metres)
1939	74.3
1940-4	n.a.
1945	91.0
1946	95.4
1947	97.2
1948	97.8
1949	98.0
1950	97.7
1951	95.9
1952	88.0
1953	85.2
1954	84.9
1955	84.8
1956	84.7
1957	84.4
1958	83.9
1959	83.3
1960	83.3

Source: Merrett (1979)

However, this anti-residualist strategy meant increased costs Malpass (1990: 77) suggests that post-war standards added 25 per cent to costs per unit and naturally this involved pressure on scarce materials. As Table 6.6 shows, there was a slow build-up at the beginning of the programme (Bridgen and Lowe, 1998: 203) and completions at the end of Labour's period of office were below the 1948 peak.

Thus, although Labour had not set itself a quantitative target, it was vulnerable to criticism on its housing programme. This was seized on by the Conservatives in both the 1950 and 1951 elections. In the 1950 Manifesto the Conservatives argued 'before the war under free enterprise, with a Conservative Government, the nation was getting a thousand new houses every day. The latest Socialist target is five hundred' (Craig, 1975: 121); and the 1951 Manifesto stressed the priority of housing and adopted a quantitative target

‘housing is the first of the social services...Our target remains 300,000 houses a year’ (ibid.: 146).

However, when it came to how the target was to be implemented there was ambiguity in the Manifesto. The comparison with pre-war completions suggested that the answer lay in private enterprise. However, a ‘liberated’ private enterprise was to be expected to produce only ‘part’ of the ‘needs for houses to rent’ (ibid.: 121) and ‘local authorities must continue to play a full part in providing a wide variety of houses and flats’ (ibid.). This ambiguity reflected a tension between Conservatives who stressed the importance of promoting owner-occupation and those who saw this as an unrealistic policy objective in the conditions prevailing in the 1940s and 50s (Jones, 1992: 137-9).

The task of implementing the target was given to Harold Macmillan, the new Minister of Housing and Local Government. As Table 6.6 shows, notwithstanding the paens to private enterprise in the Manifesto, the bulk of completions in the 1951-5 period came from municipal building. This might seem to reflect the quintessence of ‘consensus’ with the Conservatives embracing a collectivist solution to the housing shortage problem. However, as was pointed out in Chapter 1, the policy was double edged and the collectivist elements were relatively quickly discarded.

As a means of encouraging building the Conservatives increased subsidies under the 1952 Housing Act. However, such nominal increases were eroded by the higher interest rates charged by the Public Work Loan Board, at that time the principal source for the finance of local authority building (see Malpass, 1990 for discussion of the effects of higher interest rates on subsidies and (Heap to Macmillan, 1st April 1952, PRO,HLG

101/247, for an example of a complaint on this score from a local authority officer; this file contains a number of similar communications from local authorities).

Another crucial feature in reaching the target was the *reduction* in housing standards. This can be seen from Table 6.7 which shows the continuous shift to smaller properties and from the fact that whereas three bedroomed houses made up 80.6 per cent of local authority houses built over the period April 1945 to December 1951, this proportion had fallen to 64.8 per cent by 1955 (Central Statistical Office, 1961: 61). This enabled Macmillan to economise both on overall public spending allocated to housing (for an estimate of the effects of such lower standards see Jones, 1992: 244) and to squeeze more completions from a given allocation of materials.

The importance attributed to the housing target, particularly by Churchill, is illustrated by the priority given to it even against sustained opposition from the Treasury. Thus Butler continued a sustained attack against Macmillan's housing targets throughout 1952 (see for example Investment in New Building, Memorandum by the Chancellor of the Exchequer, 15th July 1952, PRO, CAB 129/53 C (52) 40; (CAB 128/25 CC (52) 70th Meeting, Conclusions, 17th July 1952). However, the issue was resolved in Macmillan's favour at the Cabinet of 24th July 1952 via the decisive intervention of Churchill (PRO, CAB 128/25 CC (52) 73rd Meeting, Conclusions, 24th July 1952).

The Road to Residualism

If the political importance of reaching the housing targets involved the use of collectivist means this certainly did not involve a long-term commitment of principle. Thus, the spending programme which grew so rapidly in the early years of the first post-war

Conservative government was put into reverse once the Conservatives were confident that the politically crucial targets were being realised.

One of the reasons for the reversal was the continued anxiety in the Party at the implications of the municipal housing programme. This surfaced both at grass roots level and at the level of the Cabinet. With respect to the former, following the (nominal) rise in subsidies Macmillan and his deputy, Marples were bombarded with protests from Conservative supporters and local Conservative associations (numerous examples can be found in HLG 101/247). In the Cabinet Woolton was concerned that 'we are concentrating unduly on the provision of Council houses, which make a considerable strain on the Exchequer' (A Property Owning Democracy, Note by the Lord President of the Council, 20th June 1952, CAB 129/53). This was inimical of a 'property owning democracy' since, so Woolton argued, subsidy was available to council tenants but not owner occupiers (*ibid.*).

Given its political salience Macmillan continued to lay emphasis on realising the target but this involved no ideological commitment to collective provision. In a draft letter to Butler of May 1953 he already raised the possibility of differential rates of local authority subsidy with a substantially higher subsidy for slum clearance as against that for 'general needs' (Draft Letter to the Chancellor of the Exchequer, Macmillan, undated, with papers of May 1953, HLG 101/433). Conservative policy continued to move in this direction culminating in the Housing Subsidies Act of 1956 which targeted slum clearance with a subsidy level for this (residualist) purpose set at over double the 'general needs' subsidy. Housing and collectivist means were accepted but there was also anxiety at the contradictions with Conservative support for owner occupation. By 1955 the

Conservatives could use the achievement of the target as a social policy success and the 1955 Manifesto stated 'our party's pledge to build 300,000 houses a year was derided by our opponents as impossible to fulfil. In fact nearly 350,000 were built last year, and at least as many are likely to be built this year' (Craig, 1975: 170). However, by the mid 1950s the Conservatives had gone back to the residualist approach seeking to restrict council building to slum clearance and targeting 'need'. The result was that the increase in housing expenditure in the early 1950s was sharp and significant but also short-lived.

Social Security: Ambivalence on Selectivity and its Effects

In this section the aim is to examine expenditure trends in social security. As was indicated in the third section, this was the most successful programme area in two senses: it was the largest programme; and the only one which 'over performed' the index throughout the period. However, its pre-empting of resources from health was in the financial not the material sense. This was because, unlike the other social service areas reviewed, social security expenditure overwhelmingly consists of transfer payments with the call on physical resources restricted to the relatively small percentage of total expenditure absorbed by administration.

Table 6.8 Expenditure on National Insurance Benefits 1951/2 to 1959/60, United Kingdom (£ million).

	1951/2	1952/3	1953/4	1954/5	1955/6	1956/7	1957/8	1958/9	1959/60
Total	399.1	474.5	498.8	510.2	618.0	639.5	701.8	907.2	941.2
UE*	16.5	29.8	24.8	17.9	18.4	23.7	28.9	54.2	45.8
S**	65.7	82.0	88.1	87.7	103.8	100.9	115.5	138.2	135.4
M***	8.6	8.9	10.8	13.3	14.4	15.3	16.5	20.3	20.6
W P+	24.6	28.7	31.3	32.8	36.7	39.3	45.0	59.1	63.2
RP++	280.4	321.5	340.4	354.7	440.7	456.4	491.3	629.6	670.2
DG~	2.6	2.7	2.8	3.1	3.3	3.4	4.0	5.1	5.3
O~~	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.4	0.4

*Unemployment benefits ** Sickness Benefits ***Maternity Benefits + Widow's Pensions ++Retirement Pensions ~ Death Grant ~~Other (Guardians and Children's special allowance).

Source: Central Statistical Office 1960 and 1961.

Table 6.8 shows the breakdown of expenditure on national insurance benefits over the period 1951/2 to 1959/60. What is immediately striking is the crucial importance of retirement pensions (RP) which consistently accounted for at least two thirds of total national insurance benefit expenditure over the period. Thus the emphasis in this section will be on pensions expenditure. The importance of pensions lies not just in their salient role with respect to social security expenditure but also because of the importance of this area in relation to poverty during the period. It was one of full employment and this is reflected in Table 6.8 in the very low levels of unemployment benefit expenditure. Equally, surveys of the causes of poverty involved a shift in emphasis in this period. Thus Rowntree and Lavers's study of poverty in York in 1950, while it found substantially reduced levels when compared to the 1936 survey of the same city, also found that 68 per cent of those in poverty were also in 'old age' (Political and Economic Planning, 1952: 27).

An examination of Table 6.8 shows the erratic pattern of expenditure increases with, in particular, major increases in expenditure between 1954/5 and 1955/6; and between 1957/8 and 58/9. The main reason for these increases were substantial improvements in benefit levels in April 1955 and January 1958 which are shown in Table 6.9.

Table 6.9 Standard Rates of Retirement Pension (Man or Woman on Own Insurance), Key Changes During the 1950s (Weekly rates).

	Single Person Rate	Married Couple Rate
September 1952	32/6d (£1.625)	54/- (£2.70)
April 1955	40/- (£2.00)	65/- (£3.25)
January 1958	50/- (£2.50)	80/- (£4.00)

Source: Central Statistical Office (1961)

In addition demographic changes meant that numbers of claimants of retirement and contributory pensions increased by 1.4 million from 4,263,000 in 1951 to 5,672,000 in 1960 (Central Statistical Office, 1961: 51). In explaining this pattern the first issue which needs to be explored is the post-war social security settlement. National insurance benefit levels were not, unlike national assistance benefits, regularly adjusted to maintain real values. This meant that, in a context of inflation, the real value of benefits were eroded and periodic upratings were, as Table 6.9 indicates, substantial.

The need to maintain real values was a key influence over Conservative policy in this area. For example, discussing a proposed uprating, in a Memorandum to the Cabinet in 1954, the Minister of Pensions and National Insurance (Peake) stated ‘the chief consideration I have had in mind in arriving at the new rates of pensions and benefits have been the desirability of restoring the value which pensions and benefits had in 1946’ (Review of War Pensions and Benefits, Memorandum by the Minister of Pensions and National Insurance, PRO, CAB 129/71 C (54) 350).

Selectivism Abandoned

However, the fact that uprating to take account of inflation was a key influence does account for why this course was adopted. This question is pertinent because, in many respects, it ran contrary to crucial strands in Conservative social policy. An alternative was to increase reliance on means testing by allowing insurance benefits to decline in real value and increasingly basing access to state support on national assistance. This would be a policy of 'selectivism' which aimed to target state provision with reference to a test of need. Indeed, as Jones has pointed out, even such a 'one nation' Tory as Iain Macleod supported such an approach. Thus, in 1949 he wrote to Quintin Hogg that 'the Conservative Party does not regard the true function of the social services to be either the provision of an average standard or the redistribution of wealth. It approves the historic function of the social services as the relief of the...needy from distress' (cited in Jones, 1992: 180).

The regular uprating of assistance benefits and the periodic uprating of national insurance benefits meant that the numbers of current assistance cases increased. In July 1948 there were 842,000 cases of weekly allowances granted by the National Assistance Board; by December 1951 this had increased to 1,462,000 and to 1,857,000 by December 1960 (Cmnd. 1410: 44). The supplementation of national insurance pensions accounted for 432,000 cases (51.3 per cent) in July 1948; 767,000 cases (52.5 per cent) in December 1951 and 1,075,000 cases (57.9 per cent) in December 1960 (calculated from *ibid.*). A situation in which a growing number of those drawing national insurance pensions were required to supplement them via assistance might have been seen by the Conservatives as

the basis for a policy of allowing the process to continue by not uprating as part of a move to a 'selectivist' solution.

However, this also involved a grave political risk since it represented a break with the post-war welfare settlement. Instead of a radical shift in policy the Conservatives tended to compete with Labour on pension benefit levels. Thus Peake argued 'from a thousand platforms we have claimed that six years of inflation have impaired insurance benefits' (Pensions Sub-Committee Pensions Review, Memorandum by the Minister of National Insurance, PRO, CAB 134/927, HA (P) 51 4).

He was suggesting that this was tantamount to a commitment to uprating. This was also the view in the Treasury in discussions of policy leading up to the 1955 uprating. Thus Otto Clarke, in a note for Butler on pensions, questioned the policy of uprating to restore 1946 values. He pointed out that 'it is very relevant that by 1948, the real purchasing power of the pension had fallen considerably' (Pensions, Clarke, 9th April 1954, PRO, T227/240). Clarke was suggesting a line of attack for the Government based on the fact that Labour had not maintained 1946 values. However, he also pointed out that such a stance was difficult for the Conservatives to sustain because 'the Chancellor will bear in mind that Mr. Peake has never resisted the 1946 argument, and indeed texts could be quoted in which he commits the Government to return to the 1946 parity' (ibid.).

However, political anxieties about the effects of a radical break from Beveridge was not the only important determinant of policy on the uprating of national insurance pensions. There was also an ambivalence on reliance on means testing. Thus, in his memo of December 1951, Peake suggested that, 'from many points of view the simplest solution would be to leave insurance benefits and pensions as they are and rely entirely on

assistance for further provision for the old and sick' (Pensions Sub-Committee Pensions Review, Memorandum by the Minister of National Insurance, PRO, CAB 134/927, HA (P) 51 4). Peake rejected this option as a potential 'breach of our election pledge' (ibid.) but he also raised another important objection. He pointed to 'a serious risk that if too many people have to resort to assistance the contributory scheme, which raises £400 million a year...would fall into disrepute' (ibid.). The source of ambivalence here was that insurance was attractive because it gave an important source of finance to the welfare state which was an alternative to general taxation.

Thus the price of sustaining the 'contributory principle' was periodic uprating and by the 1955 Manifesto the commitment to such regular increases had virtually been conceded: 'this year [the Conservative Government]...fully restored the purchasing power that parliament intended...when the main rates were fixed after the war' (Craig, 1975: 173). The uprating of January 1958 again enabled the Conservatives to claim, in the 1959 Manifesto, that the rates of retirement pension now have a real buying power over ten shillings higher than in 1951' (ibid.:) The de facto repudiation of rigorous selectivism continued because of anxieties that the Conservatives would be seen as 'anti-welfare' and because of an attachment to the funding implications of national insurance. This meant that the key driver of increased expenditure was the regular uprating of benefits,

Education: the Problematic Defence of Tripartism

Expenditure Trends: Demography and Policy

Education spending in the 1950s represented, arguably, the most significant 'competition' for health. As was demonstrated earlier, the experience of both social services in the

period to the mid 1950s was similar in that a regime of tight economy was applied. Thus, for example, Brian Simon (1991: 163) refers to Butler's 'ruthless and unrelenting pressure' on the Minister of Education, Horsburgh, during her period of office (October 1951 to October 1954). Equally, by the mid 1950s, the demands of the housing programme were being reduced and this offered potential scope for increased spending in other areas. However, an upturn in expenditure came in education rather than health and it is the aim of this section to account for this pattern. It will be argued that, while demographic changes were a significant factor in pushing up expenditure, a key determinant was the policy decision to privilege education which related to its increased salience for the politics of Conservative social policy in the 1950s.

To understand this politics it is necessary to examine the character of the 1944 Education Act and how Labour interpreted this legislation. While the Act introduced universal secondary education it did not stipulate a preferred structure for its organisation. However, the post-war Labour Government followed the recommendations of the 1943 Norwood Report which suggested that secondary education should be provided via grammar, secondary modern and technical schools (Land et al., 1992: 146), the tripartite system. This involved selection at the 11+ examination (ibid.). The official view was that each type of school was different but equal or what came to be known as 'parity of esteem' (Roy Lowe, 1988: 38-9). The division within Labour was between those who advocated 'multilateral', later comprehensive forms of school organisation and those, like the first post-war Minister, Ellen Wilkinson and her successor, George Tomlinson, who wished to retain selection in a context of 'parity of esteem' (ibid.: 39).

On the Conservative side Jones (1992: 169-170) points to an increasingly hostile attitude to ‘multilateral’ education in the early 1950s and the 1950 Manifesto gave a ringing endorsement to grammar schools (Craig, 1975: 122). However, during the period 1945-51, at least at central government level, policy was bi-partisan to the extent that both parties favoured tripartism.

As was pointed out above, when the Conservatives came into office in 1951 education was an area targetted for economies. Expenditure cuts were implemented via Circular 242 (December 1951); and Circular 245 (Februrary 1952). Such restrictions were taking place in a context not only of a higher school leaving age (of 15), implemented by Labour in April 1947 (Land et al., 1992: 148) but there was also a substantial increase in the school population driven by a higher birth rate. Thus Table 6.10 shows that infant and junior school numbers in maintained schools increased by 18.3 per cent in the period 1951-55 in England and Wales with the ‘bulge’ then transferring to the secondary schools in the late 1950s.

Table 6.10 Pupils on Registers of Infant, Junior and Senior Schools, England and Wales, 1951-1960, figures for January each year, millions.

	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960
I/J*	3.72	3.94	4.19	4.33	4.40	4.40	4.41	4.36	4.18	4.09
S**	2.01	2.02	2.01	2.03	2.11	2.24	2.35	2.47	2.71	2.82

*Infant and Junior **, Senior.

Source: Central Statistical Office (1961)

In such a context the impact of economies was severe. Thus, for example, Circular 245 of February 1952 stipulated that, because of reductions in capital spending, there was to be no building to relieve overcrowding in existing schools; to replace unsatisfactory premises; to enable the reorganisation of all-age schools; or to meet parental requests for

denominational education (unless this was connected with a new housing estate) (Capital Investment in 1952, Educational Building, Circular 245, 4th February 1952, PRO, T 227/150). In 1951 28 per cent of infant and junior classes were of 41 or more pupils; by 1955 this had increase to 29 per cent (calculated from Central Statistical Office, 1961: 85).

In terms of policy on the structure of secondary education tripartism was rigorously defended. Thus, as was pointed out in Chapter One, a leitmotif of Conservative education policy in the 1950s was the refusal to countenance comprehensive reorganisation which required closure or amalgamation of an existing grammar schools. Such policies were supported by Horsburgh (Fenwick, 1976: 98); by Eccles . (see for example, Secondary Education, memorandum from the Minister of Education, 18th April 1955, PRO, ED 136/861); and Lloyd . (see, Lloyd to Macmillan, 24th December 1957, PRO, PREM 11/4171; see also Simon, 1985: 288-9 for continuity of policy in this respect).

As was indicated earlier, the significant upturn in education spending began in the mid 1950s and a number of commentators have seen a key shift with the change in Minister in October 1954 when Sir David Eccles replaced Florence Horsburgh. Eccles has been said to have ‘transformed the Ministry’ (Bridgen and Lowe, 1998: 149; see also Roy Lowe, 1988: 90; and Dean, 1992: 3-4 for similar assessments). However, before looking at Eccles’s approach to education policy and the context in which it operated it is necessary to examine how far the substantial increase in educational expenditure reflected the accommodation of demographic change rather than policy changes. To look at this question it is useful to consider the accounts of two distinguished educational historians. Brian Simon, while noting that the percentage of Gross Domestic Product spent on

education increased during the 1950s, states that this was ‘...largely the result of an increase in the total number of pupils by over one million’ (Simon, 1991: 212). In contrast Roy Lowe (1988: 90) sees a significant upturn in educational spending in the ‘late 1950s’ and one in which he situates in policy terms. Thus he argues (ibid.) ‘the continuing policy commitment to the identification and promotion of an elite and to the underpinning of economic growth meant that the bulk of the expansion was directed at older school pupils and those in further and higher education’.

The significance of demographic factors cannot be doubted. The number of pupils on the registers of maintained or assisted schools increased from 5,737,698 in 1951 to 6,924,381 in 1960, an increase of 20.7 per cent (Central Statistical Office, 1961: 85). Equally the increase in the numbers of full-time teachers only achieved a marginal reduction in pupil: teacher ratios from 26.7 (1951) to 25.7 (1960) (ibid.). However, there is other evidence which supports an argument that the allocation of resources did not simply reflect demographic pressures. The Central Statistical Office estimate for educational expenditure at constant (1958) prices shows an increase from £414 million (1951) to £597 million in 1960, or 44 per cent in real terms and thus twice the rate of growth of pupil numbers in maintained and assisted schools (Central Statistical Office, 1966: 16-17). Equally nearly 15 per cent of the overall increase in pupil numbers reflected 175,000 more pupils staying on beyond the statutory leaving age, from 1951 to 1960 (calculated from Central Statistical Office, 1961: 85). In addition the percentage of 15-18 year olds who were part-time students in further education increased from 10.1 per cent (1951) to 13.7 per cent (1959); and the number of full-time further education

students in this age range increased from 1.3 per cent in 1951 to 3.2 per cent in 1959 (Central Statistical Office, 1958: 89; and 1960: 87).

Thus, while the demographic influence was significant it is also possible to discern some important policy shifts in driving increased spending. In this part of the argument the aim is to sketch the context for these policy shifts which led to education becoming a relatively privileged area for social services expenditure in the mid to late 1950s. As was pointed out above, Roy Lowe argued that the growth in expenditure reflected a bias to secondary, further and higher education. This is supported by the LEA expenditure statistics; in 1951 primary education accounted for 33 per cent of net expenditure, secondary schools 24 per cent and further education 6 per cent; the respective figures for 1960 were 29 per cent, 29 per cent and 8 per cent (calculated from Central Statistical Office, 1961: 91).

'Alternative Routes' and the Defence of Tripartism

Crucial to understanding this shift is the relationship of the Conservatives to the tripartite structure. As was indicated above, Conservative ministers in this period did not waver from a defence of selection. However, a central feature of the period was that the support for tripartism became increasingly difficult in part because it ceased to be a bi-partisan issue. In 1953 the Labour policy document 'Challenge to Britain' committed Labour to abolishing the 11+ (Jones, 1992: 369). This meant that the structure of secondary education became a much more salient electoral issue. On this question the Conservatives, as advocates of tripartism had a number of points of vulnerability. Of central importance was the evidence throwing doubt on the validity of 'parity of esteem'.

Thus Table 6.11 shows the marked superiority of the grammar schools in terms of resourcing with the secondary moderns having substantially higher pupil: teacher ratios.

Table 6.11: Teacher-Pupil Ratios in Different Types of Public Secondary Schools and in Independent Secondary Schools 1951 and 1959, England and Wales.

Type of School	Year	Pupils per full-time teacher
Modern	1951	22.7
Grammar	1951	18.6
Technical	1951	18.8
Independent	1951	12.7
Modern	1959	23.3
Grammar	1959	19.1
Technical	1959	19.5
Independent	1959	13.2

Sources: Cmd. 8554; Cmnd. 1088

This gap was also reflected in the qualification of teachers thus, in 1951 76.8 per cent of grammar school teachers were graduates as against 14 per cent of secondary modern teachers. The generally higher level of resourcing of grammar schools can also be seen in relative funding levels, thus Vaizey (1958: 102) estimated that ‘the average grammar school child receives 170 per cent more per year in terms of resources than the average modern school child’.

There were also major differences in the ‘destinations’ of pupils thus, for examples Tables 6.12 and 6.13 show the substantial differences in particular in access to university education.

Table 6.12: School Leavers in England and Wales, Destination on Leaving by Type of Public Secondary School, Boys, 1951 and 1959.

Type of School	Year	University	Other Further Education	Paid Employment Or Other
Modern	1951	9	2,161	176,018
Grammar	1951	5,557	2,417	37,479
Technical	1951	21	735	15,459
Multilateral	1951	77	81	3,441
Modern	1959	11	9,055	190,367
Grammar	1959	7,743	4,035	35,089
Technical	1959	143	1,292	12,120
Multilateral	1959	203	317	11,852

Sources: Cmd. 8554; Cmnd. 1088

Table 6.13 School Leavers in England and Wales, Destinations on Leaving by Type of Public Secondary School, Girls.

Type of School	Year	University	Other Further Education	Employment or Other
Modern	1951	3	5,313	170,486
Grammar	1951	2,293	9,947	32,924
Technical	1951	3	493	8,071
Multilateral	1951	49	159	3,231
Modern	1959	13	14,276	178,391
Grammar	1959	3,186	13,691	30,745
Technical	1959	9	952	7,042
Multilateral	1959	94	751	11,666

Sources: Cmd. 8554; Cmnd. 1088.

The problems with ‘parity of esteem’ were recognised by Conservative Ministers of Education. Thus Eccles observed that ‘it was hoped that the modern schools would attain “parity of esteem” with the grammar schools...but this has not yet happened’ (Secondary Education, Memorandum by the Minister of Education, 18th April 1955, PRO, ED 136/861). In a similar vein Lloyd observed ‘...relatively few secondary schools were adapted to provide instruction appropriate to older pupils and the majority were in many

respects little better than the old-style elementary schools' (PRO, CAB 128/32, CC (58), 64th Meeting, Conclusions, 24th July 1958).

Naturally, if parity of esteem was not a reality then success at the 11+ became that much more crucial. Again both Eccles and Lloyd made the connection: the former pointed out that the aim of parity of esteem was designed to ensure that 'disappointment and jealousy felt by parents when their children failed to qualify for a grammar school would disappear' but as such parity had not been achieved then 'resentment appears to be growing' (Secondary Education, Memorandum by the Minister of Education, 18th April 1955, PRO, ED 136/861). Lloyd also saw the failure of most secondary moderns as 'at the root of the current criticism of the eleven-plus examination' (PRO, CAB 128/32, CC (58), 64th Meeting, Conclusions, 24th July 1958).

This was a problem which extended to the Conservative's core constituency. In December 1957 Macmillan asked Lloyd to send him a note on the 11+ remarking that 'from what I have heard it seems to be very unpopular' (Macmillan to Lloyd, 5th December 1957, PRO, PREM 11/4171). In his reply Lloyd pointed out that, before the 1944 Act, only 10 per cent of places in grammar schools were filled by 'competitive selection'. Access to the rest of the places involved passing a qualifying examination and paying a fee. Lloyd observed that '...the class of parents who could afford these fees and did not need to send their children to work had a reasonable assurance of getting them into a school providing education up to the age of 16,17 and 18' (Lloyd to Macmillan, 24th December 1957, PRO, PREM 11/4171). However, the 1944 Act had transformed this situation and 'access to schools providing the best opportunities for continued education and entry to the professions was more thoroughly competitive...' (ibid.)

In addition to middle class anxieties in a context of a more ‘thoroughly competitive’ system of access the 11+ was also increasingly being de-legitimised as a method of selection. The examination was broadly premised on a concept of intelligence testing deemed to reveal innate capacities. However, by the early 1950s educational psychologists were increasingly suggesting that intelligence quotient scores could be substantially increased by coaching (Fenwick, 1976: 92; Simon, 1991: 176);). There were also substantial variations in access to grammar school places both between LEAs e.g. in the mid 1950s Westmoreland grammar schools accounted for 42 per cent of secondary places as against 9 per cent in Gateshead (Roy Lowe, 1988: 107-8); and within LEAs, thus Lowe (*ibid.*: 108) cites a figure of a high of 40 per cent and a low of 15 per cent grammar school places in the West Riding. There were also the critical findings of sociologists of education showing sharp class differentials in access to grammar school amongst children of comparable measured ‘intelligence’ (e.g. Halsey and Gardner, 1953).

As was pointed out above, there was a key element of continuity in Conservative policy during this period which was particularly characterised by the defence of selection. Thus the key post Horsburgh policy shift was not in respect of the status of the grammar school which remained the sanctum sanctorum of the maintained sector but rather the realisation that a response had to be made to the problems of the 11+. As Eccles put it, ‘...we cannot leave the 11+ where it is’ Secondary Education, Memorandum by the Minister of Education, 18th April 1955, PRO, ED 136/861). One possibility, was to give increased access to the grammar schools but this foundered on the defence of their exclusive status. Thus Eccles asserted ‘...the standards of our Universities and grammar schools could not be diluted...without changing their whole character’ (*ibid.*).

The alternative, Eccles argued, was ‘to construct an alternative route to high qualifications and well-paid jobs via secondary modern and technical schools and technical colleges and to encourage more transfers at 15 or 16 to grammar schools’ (ibid.). This approach was consistently argued by Conservative Ministers of Education post the Horsburgh period. Equally, it was seen as the means of defusing the critique of the 11+. In 1955 Eccles argued that, where secondary moderns had developed specialist vocational courses ‘complaints from parents about the selection process are strikingly reduced’ (ibid.). Similarly, in defending a substantially enhanced capital programme in education, in July 1958, Lloyd argued that it would raise the ‘quality of secondary schools’ and hence ‘we should...take the sting out of the 11+ examination’ (A Drive in Education, Memorandum by the Minister of Education, PRO, CAB 129/93, C (58) 148, 14th July 1958). This ‘alternative route’ strategy has been discussed in a number of the principal accounts by education historians of this period (e.g. Simon, 1991: 185 and, particularly Dean, 1992) and it is consistent with the pattern of increased expenditure from the mid 1950s onwards. It is also in line with Roy Lowe’s argument, cited earlier, that increased expenditure was concentrated on secondary, further and higher education.

Thus, from the mid 1950s Conservative education ministers developed a rationale for education expenditure which was rooted both in a political strategy designed to combat Labour criticisms of the 11+; and thus to protect an area of perceived political vulnerability in Conservative social policy.

Conclusion

This Chapter has sought to explore two key aspects of Conservative policy on NHS expenditure in the 1951-60 period. The first was the way in which NHS expenditure was

conceptualised. In this respect Abel-Smith and Titmuss's work was crucial in seeking to shift the focus away from the concerns of the 1948-51 period which were with the relationship between expenditure and out-turns and usually invoked very early estimates as standards. However, the documentary research show that there was no serious attempt in the Treasury to absorb the implications of this reconceptualisation and that, well after Guillebaud reported, references to early estimates continued to be used in order to resist arguments for increase expenditure or to press for cuts.

The crucial key feature was the relationship of different social services in terms of the politics of Conservative social policy. In a government which put a strong emphasis on control of public expenditure social services were competing for a broadly finite supply of resources. In this competition, as Webster (1996) pointed out, health was a consistent loser. In accounting for this pattern a critical feature is the relationship of particular social services to the electoral politics of the period.

In two areas, housing in the early 1950s and education in the mid to late 1950s, a positive programme of development pushed up expenditure. In both cases electoral constraints were important. In housing the Conservatives exploited an area of Labour vulnerability on an issue of great political importance. The collectivist means generated much disquiet at the Conservative grass roots and at the level of the political elite. However, it was also possible to shift direction and once the key targets had been achieved it was possible to move in the residualist direction and cut public expenditure.

Once this policy had been adopted an opportunity arose for other programmes to expand. The area where this happened was education. While the defence of tripartism was a consistent feature of policy during the period it was also increasingly problematic.

The Conservatives sought to meet the policy challenge by attempting to give more substance to 'parity of esteem' via the aim of creating a variety of routes to further and higher education. Inter alia, such a policy had to address, if not correct, the resource deficiencies of secondary modern schools. In contrast health did not pose a comparable political problem in this period and thus did not trigger expenditure in the same way. The result was that, while, structurally, the NHS of 1960 was indistinguishable from that of 1948, a regime of consistent parsimony had been applied during the period, health had become the cinderella programme of the major social services. Chapters 5 and 6 have examined how the two parties in government in the period under review defined the 'problem' of NHS expenditure. In the final two Chapters the aim is to consider two types of response to this 'problem': expenditure control, through the case of capital investment, the area in which such control was most stringent, discussed in Chapter 7; and the attempt to seek efficiency gains via 'managerial' means through the discussion of management accounting in the 1950s which will be discussed in Chapter 8.

Chapter Seven: Postponing The Future: NHS Capital Expenditure on Hospitals from the Appointed Day to the Hospital Plan

The aim of this Chapter is to discuss the capital expenditure on the National Health Service from the beginning of the Service to the early 1960s. The end of the period under consideration could be seen as involving an important break not just in relation to patterns of capital expenditure but also with respect to general approaches to NHS expenditure. This is because, by 1960, a clear basis for what was to be the Hospital Plan had been laid. Thus, as Webster (1996) has argued, Sir Bruce Fraser, who became Permanent Secretary to the Ministry of Health in 1960 (*ibid.*: 782), had, in June 1960, ‘outlined a practical scheme which contained all the elements of the [hospital] plan published in 1962 (*ibid.*: 101; for the scheme concerned see Fraser, Hospital Capital Programme, June 1960, PRO, MH 137/41). The Hospital Plan itself could be seen as a major policy shift for three main reasons. Firstly, it involved a substantial increase in the annual commitment to capital expenditure on the Service. Thus while such expenditure on hospitals in England and Wales was £20.5 million in 1959/60 (Cmnd. 1604: para. 3) the Plan outlined a programme of £707.5 million for the cost of schemes expected to start in England and Wales for the period 1961- 62 to 1970-71 (*ibid.*: 277).

Secondly, the concept of ‘planning’ meant that a much longer time horizon was adopted than had been the norm in the 1940s and 50s. In the latter period the common practice was to give capital allocations for no more than two fiscal years. However, it was argued, in the Hospital Plan, that it was ‘both possible and necessary to take a comprehensive view of hospital needs and to formulate a long-term national plan for meeting them’ (*ibid.*: para. 5).

Finally, the Plan was designed to reorganise hospital provision such that it was based on a 'concept of a district general hospital' which would 'bring together a wide range of the facilities required for diagnosis and treatment' (ibid.: para. 20).

This aspiration contrasted with the pattern of the 1940s and 50s which had been dominated by relatively small 'make do and mend' investments. For example, the Ministry of Health Report for the year ended 1949-50 stated that plans agreed between the Ministry and the Regional Hospital Board (RHBs) and Boards of Governors (BGs) 'were...mainly plans of patchwork improvement' (Cmd. 8342: 18). Furthermore, even though there was a more substantial capital programme from the mid 1950s, the Ministry of Health Report for 1955 stated that 'this programme can only be regarded as a modest start towards overtaking the arrears of capital expenditure in the hospital service' (Cmd.9857: 10).

However, while the Hospital Plan can be seen as a break in policy the thesis advanced in this Chapter is that it was an ambivalent break and this was rooted in the debate on capital expenditure on hospitals in the 1950s. It will be argued that there was a crucial difference between the policy debate on current and that on capital expenditure. As has been argued in Chapters 5 and 6, in the case of current expenditure, there was a consistent view amongst key politicians and officials that expenditure levels were excessive and that there was substantial scope for reductions in spending. This view underpinned an unrelenting pressure to control current expenditure levels.

With respect to capital expenditure the situation was different. The difference did not lie in the absence of constraints on expenditure. The distinction rather lay in the fact that the case for a larger capital programme was broadly accepted even within the Treasury. This,

in turn, raises the issue as to why the commitment to a larger and longer term capital programme was not adopted earlier. In part the reason for a continued policy of restraint related to the low political priority accorded to health in the 1950s relative to other social services which was discussed in Chapter 6. This was reflected on the capital side as well as with respect to total expenditure in particular in the treatment relative to housing in the early 1950s and to education in the middle to late 1950s.

However, there was another important obstacle relating to the approach of the Treasury. While it frequently conceded the case for a more substantial NHS capital programme, positive support was inhibited by the belief that the Ministry of Health could only justify such a larger programme if it succeeded in reducing current expenditure. Thus, for example, Webster (1988a: 216) points out that Macleod's claim for increased capital expenditure on hospitals in 1954 was considered 'sympathetically'. However, he argues that '...there was also a view that no substantial increase should be conceded unless economies were offered elsewhere in the hospital budget' (ibid.).

This approach also carried over into a distrust of the Ministry's capacity to use increased capital funding effectively. Thus a consistent theme in Treasury arguments on capital expenditure was that it should contribute to reductions in *current* expenditure. However, such priorities were accompanied by fears that the main effects of increased capital spending could be to increase rather than restrain current expenditure. Such ambivalence, it will be argued, was reflected in Treasury attitudes to the Hospital Plan.

The focus of discussion in the Chapter is on hospital capital investment. This is because of the relative significance of such expenditure on hospitals as against capital investment in local authority services. When the Hospital Plan was published the Ministry of Health

produced a document 'Hospital Building: England and Wales'. This gave statistical data on hospital capital expenditure between the Appointed Day and March 1962. Over the period total capital investment on hospitals was £190 million (Ministry of Health, 1962: 1). In contrast the Local Government Financial Statistics give data on capital expenditure on 'individual' as against environmental health. No aggregate data is given for 1948-9 but, from 1949-50 to 1961-2 total investment in this area was £34.3 million (Local Government Financial Statistics). Thus annual average hospital capital investment was substantially higher than capital investment in local authority services.

The Chapter is divided into five parts: the first examines the role of capital expenditure on hospitals in relation to some key objectives of the NHS and traces the broad pattern of such expenditure during the 1940s and 50s; the second considers the financial standards used to assess the adequacy of capital spending on hospitals in the 1950s and shows that, in terms of the range of standards used, NHS capital expenditure was generally judged too be far too low; the third section looks at the case for increased capital expenditure in the light of changing views of the role of, in particular, general hospitals in the NHS; the fourth reviews the political obstacles to increased capital expenditure on the NHS in the 1948-60 period; the final section seeks to relate the discussion of the debates over the 1948-60 period to the ambivalent policy shift represented by the Hospital Plan. A conclusion seeks to situate capital investment in terms of overall approaches to expenditure control in the NHS.

Capital Expenditure on Hospitals and Key Objectives of the NHS

Current and Capital Expenditure

As was pointed out in the last Chapter, the distinction between current and capital expenditure is usually put in terms of the temporality of the benefits expected to be

derived from the expenditure. Current expenditure is defined as providing a present benefit whereas capital expenditure is designed to generate 'benefits which go on accruing after the end of the accounting period' (Abel-Smith and Titmuss, 1956: 13). Thus capital expenditure is expected to yield benefits over more than a single annual period.

It is a feature of the NHS and, in this respect it is similar to education and distinct from housing, that total expenditure is dominated by current spending with capital expenditure making up a relatively small percentage of the total. Thus, in the fiscal years 1948-9 to 1959-60 NHS capital expenditure in the UK never exceeded 5 per cent of total NHS expenditure (calculated from Webster, 1996: 802). As has been indicated, this level was affected by the restraints on capital expenditure during this period. However, even taking the longer period to 1979/80 capital expenditure never exceeded 10 per cent of total expenditure in the UK, the peak, in 1973/4 was 9.98 per cent (calculated from *ibid.*).

Capital investment and access to health services

However, this does not mean that capital spending does not have an important impact on the operation of and objectives of the Service. Thus one criticism of health care provision before the creation of the NHS was that there were significant barriers to access to such services. These barriers were argued to be financial (lack of universal state coverage meant payment for many services at the point of use); geographical (e.g. to reach sources of treatment might require extensive travelling time); and 'psychological' (Powell, 1997b: 25) thus it was argued that the municipal hospitals which had previously been poor law institutions carried a stigma (see *ibid.*: 23-25 for discussion of these issues of access).

Capital expenditure is relevant to issues of access. Thus, in 1948, provision of 'general and special' hospital beds in England averaged 6.69 beds per thousand population (Webster, 1996: 813). However, the highest level of provision, South East Metropolitan RHB was 8.93 beds per thousand, 33 per cent above the average; while the lowest was Sheffield RHB with 5.59 beds per thousand 15 per cent below the average (percentages calculated from *ibid.*). One role of capital expenditure could be to increase bed capacity relative to population, particularly in relatively under-served areas.

However, and this (see section three) reflects shifts in the conception of the role of the general hospital, access could be approached in a different way. Beds in relation to population could be seen not as a proxy *for* hospital provision but rather as a means of obtaining *access to* the range of hospital services. In such a conception what was crucial was not so much the provision of beds as the hospital activity generated through the *use* of the hospital resources. This concept of access was reflected in the Ministry of Health Report for 1953 where it is argued that investment in pathological services and operating theatres were, as they allowed for more intensive uses of beds, 'equivalent to the addition of more beds' (Cmd. 9009: 13).

Table 7.1 shows variations by RHB areas with respect to three NHS activity measures: discharges and deaths per thousand population; new out patient attendances per thousand population; and total out patient attendances per thousand population for the calendar year 1949.

Table 7.1: Variations in NHS Hospital Activity Rates by Regional Hospital Board (RHB) Area, England and Wales, 1949.

RHB Area	Discharges/Deaths per 1000 Population	New Out-Patient Attendances per 1000 Population	Total Out-Patient Attendances per 1000 Population
Newcastle	55.4	98.0	363.8
Leeds	58.5	86.5	367.6
Sheffield	52.9	90.3	417.6
East Anglia	46.3	66.4	266.8
NW Metropolitan	54.6	105.7	491.2
NE Metropolitan	64.3	120.1	479.6
SE Metropolitan	62.8	115.1	450.0
Oxford	49.2	86.0	347.5
South Western	58.1	92.0	314.4
Wales	52.6	101.3	328.7
Birmingham	47.4	120.8	505.1
Manchester	60.4	104.2	460.0
Liverpool	70.6	137.2	528.7
RHB Average	58.1	105.8	430.6

Source: calculated from Cmd. 8342.

Considerable variations are evident. With respect to discharges/deaths the RHB average was 58.1 per thousand population but this varied from the Liverpool figure of 70.6, 21 per cent above the average, to the East Anglia figure of 46.3, 20 per cent below the average. Variations in the out-patient indicators were wider: thus Liverpool had a new out-patient rate 30 per cent above the average while the East Anglia rate was 37 per cent below the average. This meant, for example, that new out-patient attendance rates in Liverpool were roughly double those for East Anglia.

Capital investment could be significant here because better designed buildings and increased availability of higher quality equipment could increase access by allowing higher levels of bed turnover (patients per bed). This, in turn, could contribute to higher

levels of access overall and, if the investment were suitably directed, to the reduction in regional inequalities in access.

Another way in which capital investment was related to access and activity levels was via its impact on staffing levels. Thus Abel-Smith and Titmuss (1956: 51) pointed out that 16.2 per cent of hospital capital expenditure between the Appointed Day and March 1954 went on 'accommodation for staff'. Their figures related to roughly half of the period considered in this Chapter. In general the share of total capital expenditure accounted for by staff accommodation was higher in the early years of the Service. Nevertheless the figures given in the 1962 Report on hospital building show that capital expenditure on staff accommodation was just over £18 million between the Appointed Day and March 1962 or 9.5 per cent of total hospital capital expenditure (calculated from Ministry of Health, 1962).

Investment in this area was supported by RHBs and BGs because it was seen as a significant factor in nurse recruitment. In turn this enabled a higher percentage of beds to be staffed and facilitated a higher level of hospital activity. In 1949 53,021 beds were classified as 'temporarily unavailable', 10.6 per cent of the total bed complement (calculated from Cmnd. 1418). An illustration of why staff accommodation assumed such significance, particularly at the beginning of the Service, can be found in a proposal of November 1951 to build a nurses' home at the Cardiff Royal Infirmary. It argued that 'many' nurses living in converted dwelling houses were living in rooms divided into three cubicles and thus several of such cubicles 'have no windows, light or ventilation' (Acceptance of Hospital Building Proposal on "Special Scheme", 9th November 1951, PRO, MH 123/219).

The application went on to point out that ‘the accommodation is generally institutional in character, e.g. the two rooms set aside for sick nurses are shockingly small and give an impression of the old cells from casual wards’ (ibid.). The poor standard of accommodation was said to contribute to recruitment problems. There were, at the time of the application, 22 vacancies; and 122 new nursing posts would be created by the addition of new maternity and out-patient departments and an operating theatre (ibid.). Such concerns were also reflected at central government level. Thus the minutes of the Investment Programmes Committee record a need to provide more accommodation for nurses, ‘if the beds already available were to be occupied’ (Investment Programmes Committee, Minutes of the Meeting of 27th May 1948, IPC (48), 31st Meeting, CAB 134/438). Thus, while such investment was not directly contributory to patient care it was seen as indirectly important by allowing an increasing proportion of beds to be staffed.

Capital Investment and ‘Efficiency’

Another criticism of pre NHS provision was that it contributed to operational inefficiency. This was seen to stem from the lack of integration of and competition between municipal and voluntary hospitals. It was argued to lead, for example, to excessive pressures on some hospitals while others had spare capacity (Powell, 1997b: 29). While the creation of the NHS ended this division restraint on capital investment was itself a source of operational inefficiency. This can be illustrated at a local level through RHB files held at the Public Record Office in the MH 88 series. One of the RHBs whose files have been preserved was the South West Metropolitan RHB which covered hospitals in south west London, Surrey, West Sussex, Hampshire, South Wiltshire, Dorset and the Isle of Wight (Webster, 1988a: 266). In this RHB a survey committee on engineering works reported, in March 1949, that increased demands, relating to features such as

increased use of central heating, more baths and basins 'will necessitate an extension of the boiler plant which cannot be accommodated in the present boiler houses' (Survey Committee, [South West Metropolitan RHB], Urgent Engineering Works Report on the Condition of Boiler Plants, 16th March 1949, PRO, MH 88/223).

The Committee went on to point to one hospital where the likely reduction in pressure created the risk that the laundry would have to close down; and to another, where boilers were used to generate electricity on site and the supply was vulnerable to a drop in pressure (ibid.). Thus old and inefficient plant was seen as limiting the role of hospitals in providing treatment.

Make Do and Mend

As was indicated above, the limits on capital expenditure meant that the problems of inadequate buildings and equipment were only tackled in a piecemeal manner. A discussion of capital estimates for the South East and South West Metropolitan RHBs (including teaching hospitals in the area) pointed to the emphasis on spending on 'essential engineering works' and 'a large number of small items' (Clarke to Tyas, Capital Estimates, 4th March 1950, PRO, MH 123/219). It concluded that 'the result of this is that the capital allocation is exhausted before any major new works, or even major war damage rebuilding schemes for the improvement of the hospital service can be undertaken' (ibid.).

This absence of large new programmes was reflected in the fact that 'by the tenth anniversary of the NHS no new hospital had been completed in England and Wales' (Webster, 1996: 24). Equally it is worth bearing in mind that, even in the case of such 'urgent' or 'small' capital works, expenditure was spread over considerable periods. Again this can be illustrated at a local level via data from the South East Metropolitan

RHB. Table 7.2 shows the estimated costs for investment in plant and buildings for hospitals in Surrey, the 1949-50 estimates submitted and the approved level of expenditure for that fiscal year.

Table 7.2: Total Estimated Costs of Capital Programmes, estimates for the fiscal year and approved expenditure levels, Surrey hospitals, 1949-50.

Hospital	Nature of Programme	Estimated Total Cost	Estimate	Approved Expenditure
Queens	Kitchen Restoration	10,000	3,000	3,000
Epsom	Engineering services, ward annexe, operating theatre	64,815	7,000	-
Epsom	X-ray accommodation	2,000	2,000	-
Farnham	Development Plan	150	150	-
St. Lukes	Pathological lab.	7,500	5,000	5,000
Kingston	Kitchen	3,000	3,000	3,000
Smallfields	Adaptations	8,000	8,000	8,000
St. Helier	War damage	40,000	40,000	-
Wandle	Ward cubicles/repairs	3,700	3,700	3,700
St. Peters	Kitchen, dining room, outpatients	100,000	2,000	2,000
King George	Nurses quarters. Sick bay	8,500	5,000	5,000
Queen Mary	War damage, adaptation of X-ray	3,500	3,500	3,500

Source: PRO, MH 88/223

The dominance of relatively small projects is clear as is the divergence between the expected total costs of the schemes, the estimates for the fiscal year and the expenditure approved. Thus, for example, the proposed repair of war damage at St. Helier was

postponed and no expenditure approved for the fiscal year; and while the work at St. Peters was estimated at a total cost of £100,000 expenditure of only £2,000 was estimated and approved for the fiscal year.

Naturally such restrictions meant that the carrying out of even ‘urgent’ capital work was put off and this created limits on access and the perpetuation of operational inefficiencies. It also meant that such parsimony was vulnerable to the criticism that it represented a false economy. As will be discussed in the fourth section such arguments were accepted, even in the Treasury. However, before examining these issues it is necessary to examine the financial standards by which the adequacy of capital expenditure on hospitals was judged.

Hospital Capital Expenditure: Financial Yardsticks

An important theme of this Chapter is that there was a marked difference between assessments of the adequacy of current and capital expenditure in the NHS. Thus whereas there was a consistent strand of criticism characterising current expenditure as excessive this was not the case with capital expenditure on hospitals. In this section the aim is to look at these discussions with respect to various financial yardsticks applied to hospital capital investment.

Pre and Post-War Comparisons

A frequently cited standard was based on comparisons of hospital capital expenditure levels at the end of the inter-war period and those prevailing during the 1950s. The most systematic example of such a comparison was that given in Appendix G of Abel-Smith and Titmuss’s study. The pre-war figures were those for municipal and voluntary hospitals. Pre-war coverage was incomplete because inclusion in the Hospitals Year

Book, the source used for capital expenditure in voluntary hospitals, required that a return was made to the British Hospitals Association. Abel-Smith and Titmuss (1956: 137) pointed out that voluntary hospitals failing to make such returns accounted for 6539 beds in 1938 and 7479 in 1939. Equally, with respect to the post-war figures it is important to note that not all voluntary hospital bed provision was taken into the NHS as some voluntary hospitals were 'disclaimed'. To determine the number of beds involved Abel-Smith and Titmuss used the 1952 Hospitals Year Book which showed voluntary hospitals as providing 8368 available beds (*ibid.*). In both cases the bed numbers were a small percentage of total capacity and the similarities in the numbers of omissions in both periods meant, that 'they can be regarded as roughly balancing each other' (*ibid.*).

A more complex issue was that of the (accounting) definition of capital expenditure. This involved the question of how far items were treated consistently between hospitals at the end of the inter-war period; and the extent to which accounting practices in that period could be standardised with those of the NHS.

With respect to the former question there were clearly problems. Ideally classification of expenditure as 'capital' would involve treating items consistently. However, as Abel-Smith and Titmuss (*ibid.*: 138) pointed out 'in a number of cases...both voluntary and local authority, the question as to whether an item was classified as capital depended on whether it was or could be financed from loan funds rather than on the nature of the expenditure itself'. Abel-Smith and Titmuss adjusted NHS financial data to render it, as far as was feasible, consistent with common practice at the end of the inter-war period (*ibid.*).

The end of result of these labours was that pre-war capital expenditure, in 1938-9 was estimated at £9.2 million in municipal and voluntary hospitals (ibid.: 137). However, this was adjusted upwards by a further £750,000 to take into account expenditure on poor law institutions which were not included under local authority public health expenditure (ibid.: 138). This gave an overall estimate of roughly £10 million for capital expenditure on hospitals in England and Wales at the end of the inter-war period. After adjusting the NHS data they estimated that capital expenditure on hospitals in 1952/3 was £10.2 million (ibid.).

However a further adjustment which was required was for price changes. Using 'information supplied by the Ministry of Health' they estimated that the 1952/3 value of 1938/9 capital investment on hospitals was £32 million and thus that the 1952/3 level was roughly one third of the end of the inter-war level (ibid.).

However rigorously this comparison was undertaken it necessarily could only be approximate. On the other hand it is striking how frequently the 'one third' level is cited in other independent, but less rigorously calculated, sources. An internal Ministry of Health estimate of December 1953 put 1938/9 capital investment at a slightly higher figure than Abel-Smith and Titmuss, £10.6 million and suggested that, to adjust for 'current prices', it would be necessary to increase the 1938/9 figures by 3.3. This gave a 1952/3 equivalent of £35 million, slightly higher but in the same type of range as the Abel-Smith and Titmuss calculation (Marre to Clarke, Investment Programme, 16th December 1953, PRO, T 227/402). Furthermore, Otto Clarke treated the 'one third' figure as indicative of the need to increase capital expenditure on hospitals. Thus he stated 'the case for a much increased programme is, in my view, unanswerable. Hospital

investment is, in real terms, at about one third of the rate of the late 1930s...' (Clarke, Hospital Building, 20th December 1954, PRO, T 227/402).

Of course, even if 1950s hospital capital expenditure levels were substantially below those prevailing at the end of the inter-war period this did not of itself demonstrate the inadequacy of the former. Prior investment could be seen as reducing the need for a substantial programme under the NHS. However, three types of evidence rendered such a view problematic; the patterns of capital expenditure between 1939 and the early to mid 1950s; the judgements of the wartime hospital surveyors; and the age of the hospital stock.

With respect to the former, Table 7.3 shows how low local authority capital investment on hospitals was during the war and the immediate post-war period when contrasted with the Abel-Smith and Titmuss estimate for 1938/9 even if the comparison is made in nominal terms. This suggests a substantial backlog of capital projects which was consistent with, for example, concerns over the efficiency of boilers referred to above.

Table 7.3: Local Authority Capital Expenditure on Hospitals 1938-9 and 1941-2 to 1947-8, £.

Year	T.B.	Infectious Disease	General	Mental	M. D.*	Total
1938-9	518,000	1,076,000	1,703,000	1,465,000	1,150,000	5,912,000
1941-2	241,726	213,174	504,971	218,330	224,501	1,178,201
1942-3	169,210	126,355	338,733	125,104	86,912	846,314
1943-4	244,194	89,781	196,827	146,574	96,387	773,963
1944-5	184,914	33,220	176,505	133,535	50,447	528,621
1945-6	242,000	66,000	253,000	207,000	31,000	799,000
1946-7	263,000	36,000	446,000	204,000	77,000	1,046,000
1947-8	378,000	110,000	594,000	419,000	162,000	1,663,000

Sources: Abel-Smith and Titmuss (1956); Local Government Financial Statistics.

Such considerations were also reflected in the verdicts of the hospital surveys. Thus Abel-Smith and Titmuss cited the survey of Wales to the effect that 'roughly one half of the accommodation is structurally ill-adapted for the purposes for which it is used'; in Yorkshire the surveyors commented that a large number of hospitals were 'structurally unsuited to the practice of medicine and surgery on modern lines' (Abel-Smith and Titmuss, 1956: 55). Similar criticisms from surveys of four other areas were cited (*ibid.*). Equally, it is interesting, in the light of the absence of new hospital building under the NHS in the first decade of the Service, to note that the need to build new hospitals was often commented on by surveyors. For example, in their survey of London and the surrounding area, Gray and Topping pointed to a need for a district hospital in Harrow a role which, they argued, could not be fulfilled 'by any of the present hospitals even if developed' (Gray and Topping, 1945: 18).

A final index of the problematic nature of the existing stock was its age. Abel-Smith and Titmuss (1956: 54) estimated that 45 per cent of hospitals in England and Wales were built before 1891 and 21 per cent before 1861. Similar figures were produced by Macleod in a letter to Butler, where he claimed that 400 of 2000 NHS hospitals (20 per cent) were built before 1860 and only 750 (37.5 per cent) since 1900 (Macleod to Butler, 26th April 1954, PRO, T 227/402). Abel-Smith and Titmuss (1956: 54-5) pointed out that such data referred to the age of the original buildings and thus took no account of later extensions and conversions. However, they argued that the hospital surveyor views were indicative of the extent to which new building did not compensate for older original buildings.

A Target for Capital Expenditure

Thus the 'pre-war' financial yardstick, the very low levels of capital investment during the war and in the years immediately preceding the creation of the Service and under the

NHS all pointed to a backlog. This raised the question of what an appropriate norm for hospital capital expenditure should be. Abel-Smith and Titmuss derived their figure by taking the total bed complement at the end of 1952 in England and Wales, 506,368 beds and estimated the cost of 'rebuilding' at £3,500 per bed (Abel-Smith and Titmuss, 1956: 53). This gave a capital value of £1750 million. An annual capital expenditure figure was derived by taking two norms for possible lives of hospitals. These were sixty years when 'expert opinion would suggest...the stage will have been reached when substantial refitting will be desirable' (ibid.); and ninety years when 'the vast majority of hospital buildings will be quite obsolescent' (ibid.). This gave two possible annual figures £20 million (on the ninety year assumption) and £30 million (on the sixty year assumption) (ibid.: 55-6).

However, it is important to note two qualifications to these figures. Firstly, Abel-Smith and Titmuss's estimate for costs per bed excluded any allowance for 'any change in function' (ibid.: 53). Secondly they pointed to the fact that the NHS was starting with a relatively old stock and 'considering the age and condition of the existing hospitals and the low level of investment during and after the war, figures of £10 or £20 million higher might be thought necessary according to the rate at which it is desired to raise capital to an adequate standard' (ibid.: 56). Taking this latter caveat the Abel-Smith and Titmuss norm was effectively from a 'low' of £30 million (£20 million on a 90 year hospital life plus £10 million to make up the backlog) to £50 million (£30 million on a 60 year hospital life plus £20 million to make up the backlog).

These figures are interesting in the context of the recommendation for increased hospital capital investment made in the Guillebaud Report. This was £30 million per annum and

referred to a target for the UK (Cmd 9663: para. 319). The Abel-Smith and Titmuss figure was for England and Wales and it is necessary to adjust it to allow for comparability. This can be done in an approximate way by assuming that hospital capital expenditure in England and Wales was 85 per cent of the UK total (for expenditure in levels in England and Wales on one hand and Scotland on the other in the 1950s, see Webster, 1988a: 218, these are consistent with this broad assumption). Thus the equivalent Guillebaud figure for England and Wales was £25.5 million.

A further norm is contained in a Treasury estimate. This used a broadly similar method to Abel-Smith and Titmuss. It took a similar bed complement figure 500,000 beds but used a lower capital value per bed, £3,000 thus generating a capital value of £1500 million. However, in this estimate the 'useful life' of hospitals was put at 50 years which was described as 'rather conservative'. This gave an annual norm of £30 million (Workman, Capital Expenditure, PRO, T 227/402). Thus it is worth noting that both the Guillebaud and Treasury estimates are pitched at the bottom of the de facto Abel-Smith and Titmuss range.

Nevertheless, as Table 7.4 shows, the £25.5 million-£30 million norms though, arguably, relatively conservative significantly exceeded not only capital spending on hospitals in the early years of the Service but also the rather higher levels prevailing from the mid 1950s. Amongst key policy makers the financial yardstick used suggested that, not only had capital investment at the beginning of the Service been well below the appropriate levels, but they continued to be inadequate even after the increases of the mid to late 1950s. If, however, such financial yardsticks pointed to the case for a more substantial capital programme this was also reinforced by arguments relating to what was

seen as the changing function of the acute hospital. These arguments are explored in the next section.

Table 7.4: NHS Capital Expenditure on Hospitals (England and Wales) 1948-9 to 1959-60.

Year	Expenditure
1948-9 (annualised)	£ 7,209,135
1949-50	£ 8,682,775
1950-51	£ 9,655,547
1951-52	£ 9,188,760
1952-53	£ 9,188,760
1953-54	£ 8,779,507
1954-55	£11,338,846
1955-56	£11,484,710
1956-57	£14,240,705
1957-58	£18,764,590
1958-59	£21,284,428
1959-60	£21,151,582

Source: Civil Estimates, Class V.

Changing the Role of the General Hospital

Arguments relating to the changing role of the general hospital can be approached by considering the issue of the age of the hospital stock raised in last section. Age was a relevant issue for two reasons: because of the effects on the physical fabric of the building; or in terms of the design of the hospital in relation to its function, an issue which had been raised in the reports of the hospital surveyors. With respect to the latter a building while still viable in terms of its physical fabric could have a design or standards of furnishing and equipment which could be seen as ‘obsolete’.

Increasing hospital activity levels

Issues relating to design and equipment of hospitals were particularly related in the 1950s to conceptions that the role of general hospitals was to promote acute care by increasing bed turnover (patients treated per bed). This view was manifested in a number of ways. It

was reflected in a sharp downward revision in acute bed provision norms. Thus as Allen (1981: 8) has pointed out, the wartime hospital surveys operated with a norm of 6 acute beds per 1000 population but that, by 1960, a figure of around half that level was regarded as appropriate. An important example of the basis of such downward revisions came with the Nuffield Provincial Hospitals Trust text, *Studies in the Function and Design of Hospitals*, published in 1955. Part of this study was concerned with estimating bed norms for acute hospitals and was based on survey data from Northamptonshire and Norwich. This concluded that, at an 85 per cent occupancy rate, 2 acute beds per thousand population was satisfactory (Nuffield Provincial Hospitals Trust, 1955: 182). Such much lower norms were also supported by Barr's survey of Reading hospitals which came to a similar conclusion that, at 85 per cent occupancy 1.97 acute beds per thousand population was required (Barr, 1957: 1106).

These lower bed norms reflected an emerging view that general hospitals were, and should be, making more intensive use of their complement of beds. Thus, for example, the Chief Medical Officer's Report for 1952 included a chapter on the utilisation of hospital beds. This pointed out that whereas, over the period 1949-52, available maternity beds and beds for the physically sick had increased by 7.5 per cent, patient discharges had increased by 17 per cent (Cmd. 9009: 188). This was seen, by the Chief Medical Officer, as a trend which should be encouraged since 'under the present circumstances it is only with the greatest difficulty that the number of beds can be increased. There is, therefore, all the more reason that the most effective use of what beds are available' (ibid.).

The achievement of higher levels of activity was seen as a substitute for more beds. Thus the Report estimated that ‘if the...average duration of stay of each patient in our general hospitals ...could be shortened by one day it would be possible in the existing beds to treat 195,000 more patients...To handle an additional 195,000...patients at the present average duration of stay about 8.500 more beds would be needed’ (ibid.: 192).

This increasingly intensive use of acute beds can be seen to be a consistent trend during the 1950s and the relevant data is shown in Table 7.5.

Table 7.5: Available Beds (AB) and In patients, discharged and died (DD), hospitals in England and Wales, 1949-1960, AB, numbers, DD in millions.

	49	50	51	52	53	54	55	56	57	58	59	60	
AB	448 057	456 150	462 255	468 255	473 559	476 887	476 433	476 870	477 375	476 796	475 286	472 668	
DD	2.9	3.1	3.2	3.4	3.5	3.6	3.6	3.7	3.8	3.9	4.0	4.1	

Source: Cmd. 9566 and Cmand. 1418.

The increase in hospital throughput is shown by the fact that inpatients discharged/died increased by 40.8 per cent, from 2.9 million to 4.1 million as against a 5.9 per cent increase in available beds, from 448, 057 to 472,668, over the period. Equally, while available bed levels increased from 1949 to 1954 after that point the level was broadly flat.

Early Ambulation

Such trends towards more intensive use of acute beds to facilitate access were also reinforced by changes in medical views regarding bed rest. Thus Armstrong (1998: 450-1) has pointed to a shift away from the a view that lengthy bed rest was therapeutically valuable to one in which ‘early ambulation’ was seen as desirable. He illustrates his argument from a textbook by Atkins, *After Treatment* a guide addressed to general practitioners, house officers, ward sisters and dressers and dealing with treatment after

operations. The first edition (1942) took a relatively sanguine view of bed rest and included the injunction that patients who had undergone a general anaesthetic 'should not be hurried out of bed' since they have 'often suffered a greater shock to the system than...the doctor realises' (Atkins, 1942: 15). In contrast by the fourth edition (1952) 'early post-operative ambulation' was seen as 'a desirable practice' (Atkins, 1952: 22). The positive effects of early ambulation were characterised in the following way: 'early rising diminishes the incidence of most vascular and pulmonary complications, speeds up recovery and reduces the period of convalescence' (ibid.; see also Armstrong, 1998: 451 for a survey of medical arguments favouring early ambulation in the 1940s and 50s). Support for early ambulation was also embodied in official reports. Thus the Chief Medical Officer's Report for 1952, while it stated various caveats, argued that early ambulation 'if it is properly operated,... is appreciated by the patients, shortens their length of stay in hospital...is burdensome for the nursing staff during the first few days, but considerably lightens their subsequent burden' (Cmd. 9009: 195).

Early ambulation could thus be seen as contributing to reducing length of stay and promoting more intensive use of beds but also improving treatment by combatting what were now seen as iatrogenic effects of excessive confinement to bed. However, Goodall's investigation, in 1951, suggested that, while early ambulation was obtaining increasing medical support it was reflected in hospital practice only to a limited extent. This study sought to classify patients into one of three categories; bedfast; partially ambulant, able to get out of bed to wash; and fully ambulant, able to get out of bed for hours at a time (Goodall, 1951: 3). With medical and nursing assistance Goodall sought to classify patients into the three categories using *two* distinct criteria. These were 'traditional'

criteria which emphasised the value of bed rest; and ‘early ambulation’ criteria which emphasised the importance of getting patients out of bed as soon as feasible. These were then contrasted to current hospital practice. Table 7.6 is drawn from Goodall’s study and shows not just the substantial difference in practice which could be expected to flow from the use of traditional and early ambulation criteria but also that current practice was much closer to ‘traditional’ approaches.

Table 7.6: Classification of a sample of general surgical patients and comparison with current hospital practice (1951), percentages.

	Bedfast	Partially Ambulant	Fully Ambulant
Actual	50.3	20.0	29.7
Early Ambulation	16.4	35.0	48.6
Traditional	66.7	17.3	16.0

Source: Goodall (1951).

In this respect Goodall made a connection between the dominance of a practice close to ‘traditional’ criteria and the facilities available in wards. Thus he argued that, as an early ambulation policy went along with patients washing themselves, then this meant an increase in the number of baths available (Goodall, 1951: 46). This argument was later developed in the Nuffield Provincial Hospitals Trust study on hospital design. This suggested that ‘very few hospitals’ were equipped to meet current needs in this respect (ibid.) and ‘it appears that many more patients would be permitted to get up if the necessary facilities were provided’ (Nuffield Provincial Hospitals Trust, 1955: 16, see also Hughes, 2000: 3 and James and Tatton-Brown, 1986: 69).

This suggested that the substantially Victorian heritage of the NHS was problematic not just because of the problems of the physical fabric but also because such hospitals were designed for a regime of relatively long-stay patients. Thus the arguments for increasing access via higher acute hospital throughput and the therapeutic claims made for early

ambulation reinforced the arguments based on financial yardsticks. This, in turn, raises the issue as to why, given such a broad basis of support, capital investment levels remained so restricted. This question is addressed in the next section.

The Politics of Hospital Capital Expenditure before the Hospital Plan

In trying to explain such persistent restraint two aspects will be examined: the pattern of political negotiation over hospital capital expenditure; and the approach taken to the issue by the Treasury.

Political Constraints

With respect to the political negotiations two broad periods can be distinguished. In the first material controls were exerted on capital investment including licensing of building and allocation of scarce materials. Broadly this period extended to November 1954 when licensing of building ceased to operate (Dow, 1964: 150). In the second period the constraint was more clearly financial i.e. it reflected an unwillingness of government to increase public expenditure in this area.

In the first period the broad pattern was that, under both Labour and Conservative governments, material allocations were targeted on industrial investment with social services generally in a subordinate role. Key decisions were taken by the Investment Programmes Committee (IPC) which had been created during the immediate post-war investment boom when demand was far in excess of the capacity of the economy to supply the required labour and materials (Tomlinson, 1993: 12). The IPC recognised the likely impact of such constraints on NHS capital investment. Thus, in a discussion of plans for the 1949-52 period, IPC minutes record that 'no attempt has been made to prepare a programme on the basis of the need for hospital beds in relation to the population of the country. All that it would be possible to do during the period under

review...[is] to carry out sufficient maintenance, repair and improvement to keep the number of beds at the present level...' (Investment Programmes Committee, Minutes, Meeting of 27th May 1948, IPC (48), 31st meeting, PRO, CAB 134/438).

The shift from material controls, coinciding as it did with a more limited public housing programmes (discussed in Chapter 6) seemed to open the possibility for a substantially larger NHS capital programme. However, the pattern of the mid to late 50s was one of limited increases which were frequently contested (see Webster, 1988a: 216-20 for detailed discussions of these disputes). At the political level the restraint in capital expenditure reflected the low political priority accorded to all health expenditure in the 1950s.

The Treasury View

However, while restraint on current and capital expenditure was a characteristic of this period there were important differences in the perceived legitimacy of such constraints in the two spheres and the political differences significance of such differences can be explored by looking at Treasury views on NHS capital expenditure. It was pointed out earlier in the Chapter that the case for substantially increased capital expenditure on hospitals was recognised in the Treasury. Thus Otto Clarke argued, as early as April 1954, that 'the hospitals are living on capital and have been doing so for 15 years – the day is coming when really large capital expenditure will be imperative' (Clarke, Hospital Expenditure, 29th April 1954, PRO, T 227/402). Equally he accepted that the make do and mend pattern generated false economies: thus he claimed that the existing pattern of expenditure 'encourages extravagant use of the small amount of money allocated' (ibid.). In December of the same year Clarke reiterated his view that a powerful case for increased hospital building existed and that delay raised the threat of less not more

control over expenditure: 'with a National Health Service we must build new hospitals sometime. The longer we delay the less the chance of keeping the programme within bounds' (Clarke, Hospital Building, 20th December 1954, PRO, T 227/402).

However, there was another side to Treasury thinking on this issue. This involved two key reservations: that an increased Ministry of Health capital investment programme could not be supported unless reductions in current expenditure were also forthcoming; and that Ministry of Health priorities for capital investment were misplaced and gave insufficient attention to revenue-saving measures.

With respect to the first issue Clarke's memorandum of the 29th April 1954 had marked similarities, in its support for increased capital expenditure, to the case made by Macleod in a letter to Butler three days earlier. However, there was also a crucial difference. Thus Clarke argued that '...it is obvious that the Minister has no idea of thinking out means of making the Service more efficient and cheaper' (Clarke, Hospital Capital Expenditure, 29th April 1954, PRO, T 227/402). Clarke was looking for a quid pro quo, while there was a powerful case for increased capital spending Treasury support would be facilitated by evidence of expenditure cuts and/or increased charges.

Thus one source of Treasury ambivalence on capital investment was the perceived failure of the Ministry to sufficiently control overall expenditure or levy charges to reduce net expenditure. The other key problem was Treasury distrust of Ministry of Health priorities. In particular a common concern was the lack of priority accorded to revenue saving schemes. The latter, in particular, referred to engineering works involving the replacement of inefficient plant. Thus arguments were put forward for a greater emphasis on investment which reduced running costs (Mitchell, Capital Investment

Ministry of Health, 24th November 1953, T 227/402); and there was also support for a higher priority to be given to revenue saving projects and thought that this should be tied to any increase in the capital programme (Kelley to Workman, 22nd November 1954, PRO, T 227/402).

However, as the Guillebaud Committee pointed out ‘...expectations of considerable reductions in current expenditure as a result of what are termed revenue saving schemes may only be partially justified’ (Cmd. 9663: para. 315). The reason was that, while a genuine efficiency saving might occur it could be used to improve standards of provision for patients or as a means of supporting higher activity levels. Thus, ‘when, for example, new heating or steam raising plant is introduced it will often be the case that advantage will be taken of the opportunity to improve the standard of heating...’ (ibid.). As a result while ‘the hospital will get better value for its money’ nevertheless ‘the running costs per annum...may be the same or even higher than before’ (ibid.).

Equally, although putative support for revenue saving was strong within the Treasury this possible effect was not lost on Treasury officials. Thus it was argued that higher heating standards could lead to no reduction in overall costs when inefficient plant was replaced (Kelley to Workman, 22nd November 1954, PRO, T 227/402). Consequently such investment was sometimes defended more on a best of a bad job basis thus it was claimed that the ‘increased cost’ from replacing inefficient plant was ‘likely to be less than in increasing accommodation’ (ibid.).

Thus the Treasury approach to capital investment in hospitals was ambivalent. On one hand there was a recognition of under-investment and that a planned programme would be desirable. On the other there was the desire for a quid pro quo on current expenditure;

and a suspicion that even the favoured 'revenue saving' investment would not reduce current costs and could even trigger increases. The final section of the Chapter it will be argued that this ambivalence also characterised the Treasury approach to the Hospital Plan itself.

The Hospital Plan

Many of the key features of the Hospital Plan reflect the debates on capital investment in hospitals in the 1950s. The Plan embodied the notion of a focus on increasing acute hospital throughput rather than increasing bed numbers: 'improvements in the hospital service have already done a great deal to enable more patients to be treated in a given number of beds. With the acceleration of physical improvements, the greater concentration in district general hospitals and the greater efficiency generally, the average number of patients per bed may be expected to increase still further' (Cmnd. 1604: para. 12). In line with this approach the Minister of Health, Enoch Powell, characterised the hospital bed as the unit which was used in assessing 'how many patients would be receiving the various sorts of hospital treatment at any one time' (cited in Shepherd, 1996: 214).

There was also a concern that a piecemeal approach to investment was problematic. Thus it was claimed that 'a plan is needed in order to ensure that the hospital building programme as a whole proceeds in accordance with well ordered and consistent principles' (Cmnd. 1604: para. 5). The Treasury also accepted that the previous treatment of health on the capital side justified a substantially increased programme, reflecting similar arguments used in the mid 50s. Thus it was claimed that '...the capital sums allocated- at any rate those announced before the last General Election – had fallen so far

short of “requirements” as to make it very difficult to plan intelligently...’ (Robertson, Hospital Capital Expenditure, 25th November 1960, PRO, T 227/1310).

However, the reference to the ‘last’ (1959) General Election was indicative of certain key changes which enabled a long-standing case for higher capital expenditure to be translated into a programme. In the Election, capital expenditure on hospitals surfaced as an issue. Thus Labour committed itself to a ‘minimum’ programme of £50 million a year on hospital development (Craig, 1975: 225); and the Conservatives responded by promising to ‘double’ the hospital capital programme (ibid.: 219). As will be shown below, this pledge was used by the Ministry to make a case for a significant increase in hospital capital expenditure.

The Ministry and the Treasury

There was also an important change in the Ministry’s relation to the Treasury in this period. In July 1960 Enoch Powell became Minister of Health. Not only did this mean that the Conservative Party’s leading economic liberal was now Minister but also Powell had previously served as Financial Secretary to the Treasury and was part of the full Treasury ministerial team which resigned in 1958 over what they considered to be inadequate cuts in planned government expenditure (Jarvis, 1998).

Powell’s move to a ‘spending’ ministry did not involve a corresponding shift in his economic philosophy. Thus he carried out a substantial economy programme including increased charges on dentures, spectacles and prescriptions (Webster, 1996: 89); and he also agreed a ‘contract’ with the Treasury which limited the overall growth rate of NHS expenditure to 2.5 per cent per annum (Webster, 1994: 59). Webster has characterised the shift in the Ministry’s political approach as follows ‘until 1960 the campaign for economies in the NHS was spearheaded by Treasury ministers and Ministers of Health

were reluctant participants' (ibid.: 63). In contrast, under Powell, 'the Treasury and the Ministry of Health were agreed in their philosophy towards the welfare state in general and the NHS in particular' (ibid.).

As will be argued below, Powell's support for the Hospital Plan was, in part, premised on assumptions that it was compatible with, at worst, modest increases in current expenditure. Equally, when he presented his economy proposals in the House of Commons in February 1961 the possibility of a Hospital Plan was seen as being linked to reductions in net expenditure. Thus he told the House that while the Government aimed to continue the policy of developing the Health Service' steps to 'reduce the net estimates' were 'necessary' since such developments would be threatened 'if the cost of the Service to the Exchequer were allowed to go on increasing at so high a rate' (Powell, Hansard, Parliamentary Debates, Commons, 1960-1, Vol 633, Col. 988 , 1 February 1961). Such quid pro quo arguments were viewed sympathetically in the Treasury. Thus, in December 1960, a comment on the proposed Hospital Plan stated, in the light of Powell's economy programme argued that 'one can see that the Minister wants some counterweight to the criticism that his economies will evoke' (Douglas, Hospital Service White Paper, 30th December 1960, PRO, T 227/1311).

Thus, one important shift in the Treasury-Ministry relationship was, from a Treasury point of view, a sympathetic Minister. The other key change was a new Permanent Secretary, with appointment of Sir Bruce Fraser in 1960. While this did not lead to a slackening of Treasury vigilance with respect to the Hospital Plan Fraser, a former Treasury official, did bring an ability to pressurise the Treasury via a fluent and sophisticated use of capital expenditure financial yardsticks. This facility can be

illustrated by examining an important letter to Otto Clarke of November 1960. Clarke had asked Fraser to comment on the implications of the Conservative 1959 election pledge on hospital capital expenditure and the Guillebaud norm for such expenditure discussed above.

Fraser exemplified the implications of the pledge by suggesting that, for example, the 1959/60 and 1960/61 approved capital expenditure figures of £22 million and £25.5 million respectively would correspond to commitments to £45 million and £50 million for 1964/5 and 1965/6 respectively. Thus 'doubling' was seen as occurring over the life of the parliament (Fraser to Clarke, 17th November 1960, PRO, T 227/1310).

His letter also contained a very detailed account of norms for capital expenditure in the 1950s. Thus he pointed out that Abel-Smith and Titmuss's suggestion (discussed above) that, on a 60 year hospital life basis, capital expenditure ought to be £30 million a year was based on figures which were probably an underestimate at the time (the estimate was made at 1952 prices). Abel-Smith and Titmuss had assumed £3,500 per bed but by 1960 'we would certainly not assume a figure of less than £5,000'. This, in turn, meant that the Abel-Smith and Titmuss figure needed to be adjusted to £40 million a year (*ibid.*). Equally, Fraser also pointed to Abel-Smith and Titmuss's rider that the stock was already very old and that this could necessitate a larger programme.

With respect to the Guillebaud norm Fraser made a number of telling points. He argued that, if it were adjusted for inflation, then it would correspond to a 1960 figure of £32.25 million (*ibid.*). This was the UK figure and the corresponding figure for England and Wales he put at £28.5 million. On this basis he pointed out that actual expenditure for 1958/9 and 1959/60 and the estimate for 1960/61 were still below the revalued

Guillebaud norm. He went on to demonstrate that even a substantially larger programme, modelled on the Conservative election pledge, would not prove more expensive, on a cumulative basis, than the revalued Guillebaud norm until 1963/4 (Table 7.7 reproduces the table which Fraser appended to his letter). Thus, from a range of different standpoints, Fraser built a powerful case that a substantially increased capital programme could be defended by reference to the key yardsticks which had been used in 1950s discussions of the issue.

Table 7.7: Revalued Guillebaud capital expenditure norm contrasted with a projected hospital capital expenditure programme based on the Conservative election ‘pledge’ (£million).

	‘Pledge’ Annual	‘Pledge’ Cumulative	Guillebaud Annual	Guillebaud Cumulative
1958/9	19.4 (actual)		28.5	
1959/60	20.5 (actual)	39.9	28.5	57
1960/61	23.5 (estimate)	63.4	28.5	85.5
1961/62	31	94.4	28.5	114.0
1962/63	36	130.4	28.5	142.5
1963/64	40	170.4	28.5	171.0
1964/5	45	215.4	28.5	199.5

Source: Fraser to Clarke, PRO, T 227/1310

The capital expenditure backlog, the Manifesto commitment, Powell’s soundness and Fraser’s effective use of financial yardsticks all tilted the balance in favour of the Hospital Plan. However, as Webster (1994: 58) has argued there is ‘less evidence for expansion than appears on the surface’. This characterisation is certainly reflected in persistent Treasury doubts vis a vis the Plan.

The first key reservation related to a continued Treasury resistance to *explicit* long-term capital expenditure commitments. Thus, for example, it was argued, in the context of a suggested quinquennial plan, that figures for the last three years were to be merely ‘illustrative’, should not be divulged to RHBs and BGs and ‘do not commit the

government in any way' (Douglas, Hospital Service White Paper, 30th December 1960, PRO, T 227/1311).

The other problem related to the perennial Treasury concern with overall NHS expenditure and thus the dominant element in such expenditure, current expenditure. At some points Powell defended the Plan as an economy measure in itself. Thus he argued that it 'could... be defended as an instrument of economy insofar as the replacement of old hospitals by new ones which could be run more efficiently was the best form of economy' (cited in Shepherd, 1996: 220).

However, this was in danger of conflating efficiency with economy and missing the point, in the Guillebaud Report, that more efficient use of buildings and equipment did not equate to reductions in overall expenditure. In more sober formulations Powell admitted that, after allowing for hospital closures, 'the net effect will be an increase in revenue expenditure' (Powell to Brooke, 26th October 1961, PRO, MH 137/41). The consistent line taken on this issue by the Ministry was that the increase would be of the order of 2 per cent per annum. This was the figure cited by Powell in his letter to Brooke, the Financial Secretary to the Treasury of 26th October 1961; and also the one used by Ministry officials in accounts of the expected impact of the Plan on current expenditure (e.g. Note of a meeting held in Mr. Clarke's room in the Treasury, 6th October 1961, PRO, T 227/1311). However, no firm foundation was given for the figures and Treasury officials were sceptical. Thus one expressed himself 'suspicious' of the 2 per cent per annum figure and expected the impact on current expenditure on the Plan to be higher (Vintner, Hospital Programme, 23rd October 1961, PRO, T 227/1312). The Hospital Plan was thus an ambivalent policy break. It did represent a more substantial commitment to

renewing the hospital capital stock and enabling hospitals to facilitate higher activity levels. On the other hand the attitude of the Treasury was acquiescent but also wary. This scepticism effectively repeated Treasury concerns that the NHS was spending too much and that a substantial capital programme would not cut and was likely to increase such current expenditure levels.

Conclusion

The case of capital expenditure is significant in the context of the general issue of financial control in the NHS in this period. A central conclusion from the research in this Chapter is that the combination of very low levels of capital expenditure and the operational inefficiency which resulted from them meant that, even in the Treasury, the desirability of a larger and longer term capital programme was accepted. However, this acceptance still operated within a framework in which economy in NHS expenditure remained the leading objective. The Treasury remained convinced that NHS overall expenditure was too high and thus that room for a larger capital programme should be created either through cuts in current expenditure or greater use of charges. In this respect the research takes up a theme which Lowe (1989 and 1997a) has explored more generally with respect to the Treasury. This is that, even when longer time horizons in financial control were contemplated, as in the Public Expenditure Survey Committee (Lowe 1997a), this was still within a framework in which economy in public expenditure took precedence. In this respect efficiency and 'value for money' were sacrificed in favour of economy. Similar approaches can be seen in Treasury reluctance to give wholehearted support to a more substantial capital programme in the 1950s even when the deficiencies of 'make do and mend' were recognised. It also surfaced in later reservations on the

Hospital Plan. This was a departure into longer time horizons for financial control but, while Treasury officials could see the case for such a departure, they remained suspicious of the long-term financial commitments which this involved. Chapter 8 takes this issue further by looking at a potential route to a more efficient NHS which might not have required a major investment of resources, the transformation of NHS management practices.

Chapter 8: Managerialism Avant La Lettre? Management Accounting in the NHS in the 1950s

Introduction

The object of this Chapter is to examine how far concerns with the ‘problem’ of NHS expenditure led to an emphasis on the need to change managerial practices in order to improve NHS organisational performance. To explore this the argument considers attempts to apply management accounting techniques to the running of British hospitals in the 1950s.

The Chapter is divided into four sections: the first examines the way in which the application of management techniques in the British public sector has been analysed in current theories of ‘new public management’ (NPM). It suggests that the approach adopted in NPM tends to see the period under review as one of *public administration* where management techniques were largely irrelevant to the running of public sector services. In this respect NPM approaches would suggest that, insofar as expenditure is seen as a ‘problem’, the response will be to reduce the scope of provision or discourage usage (e.g. via charges) rather than attempt to improve service efficiency by the application of management techniques. The second section considers the periodisation implied in NPM theories in the light of the way in which NHS hospital costs were presented. It shows that the approach to presentation of costs at the outset of the Service effectively continued practices which had been used in voluntary hospitals and by some larger local authorities. This ‘subjective’ approach classified expenditure under various headings which showed expenditure on service ‘inputs’ such as types of labour or categories of bought-in materials. Such a mode of presentation could be seen as fitting public administration presuppositions. Thus accounts, presented in this form, would

facilitate accountability to Parliament since how expenditure was allocated over different types of input could be traced. However, it could also be regarded as deficient as an accounting tool to aid hospital management. Thus this form of accounting could be seen as confirming the implicit NPM view of the 'non-managerial' character of the NHS in this period.

However, it is argued that this view is inconsistent both with certain aspects of the 'subjective' approach to costing as presented in the NHS Costing Returns first published (in 1952) for fiscal year 1950-51; and with a systematic critique of the 'subjective' approach which can be found in professional accounting journals and in two important semi-official reports from the Nuffield Provincial Hospitals Trust (NPHT) (1952) and King Edward's Hospital Fund for London (henceforth King's Fund) (1952). Equally this critique was substantially endorsed by the Guillebaud Committee in its Report. It suggested that the subjective approach was flawed and should be replaced by an internal hospital accounting system based on management accounting principles which would aim to set normative standards for departmental costs in hospitals. Both this critique and the fact that the NPHT and King's Fund reports were commissioned by the Ministry of Health suggests that the characterisation of this period of the NHS as involving an antipathy to managerial techniques is over-simplified. Furthermore, following these reports, a Working Party on Hospital Costing was established and its Report (Ministry of Health, 1955) led to a modified form of the 'subjective' approach which was introduced to larger acute and mainly acute hospitals from April 1957.

The third section discusses attempts to introduce management accounting in hospitals as a managerial reform project and this is illustrated by detailed reference to the two reports.

It is argued that they can be viewed as arguing for the application of techniques in the NHS which parallel similar arguments for improving standards of industrial management in the private sector via the use of management accounting. These parallels are examined by looking at the report of the Anglo-American Productivity Council (AAPC) and it is compared to the two reports on cost accounting in hospitals. The fourth and final section argues that the application of management accounting was limited by difficulties in adjusting NHS organisational presuppositions to those presupposed in the management accounting literature; and in finding an analogy to the material products or processes used in management accounting discussions of manufacturing settings. A conclusion seeks to locate this exercise in public sector management in the context of the financial control issues discussed in the thesis.

The NHS in the 1940s and 50s: a case of ‘Public Administration’?

An influential concept in current debates on the application of managerial techniques to public sector services is ‘new public management’ (NPM). While periodisations vary NPM refers to a set of techniques, practices and organisational structures which were applied in public sector services in a systematic way from the early 1980s. Since this approach is seen as ‘new’ this implies a contrast with a different set of practices which operated ‘before’ NPM. This ‘before’ phase is characterised by Dunleavy and Hood (1994) in the title of their article *From Old Public Administration to New Public Management*.

Thus NPM is conceptualised as the successor to ‘public administration’. This in turn raises the issue of the central distinctions between these approaches to the organisation of public services. In discussing the shift from ‘public administration’ to ‘NPM’ Dunleavy

and Hood (1994: 9) see it as, *inter alia*, as involving 'reworking budgets to be transparent in accounting terms with costs attributed to outputs not inputs, and outputs measured by quantitative performance indicators'. This characterisation provides part of the basis for a distinction between public administration and NPM approaches. In NPM the focus is on the costs of the *products* of public sector services or 'outputs'. In turn these can be seen as linked to 'quantitative performance indicators' which serve as the measures of such 'outputs'. Hence costs must be linked to service outputs in NPM. In turn the rationale for such a link is the definition of what Hood (1991: 4) has termed 'explicit standards and measures of performance'.

Such cost and performance standards are a crucial method of management control under NPM since they are the means of determining whether policy objectives are being achieved. In turn this involves an approach to management which Dunleavy and Hood (1994: 9) characterise as moving 'down grid' or 'reducing the extent to which discretionary power (particularly over staff, contracts and money) is limited by uniform and general rules of procedure' (*ibid.*). Detailed controls are not seen as necessary because management control operates through 'explicit performance standards'. Equally it is counter-productive because it necessarily constrains use of management discretion to achieve such performance targets (for a discussion of the internal logic of such a position, see Cutler and Waine, 1997: 2-4).

This approach to management control also has implications for organisational structures and practices since control is via evaluation of performance in relation to standards or objectives it must be possible to clearly locate *responsibility* for such performance. Thus,

in characterising NPM Hood (1991: 4) argues that 'accountability requires clear assignment of responsibility' (see also on this aspect, Cutler and Waine, 1997: 4).

The emphasis on such general approaches to management has another significant implication, it involves the assumption that management techniques are 'portable', i.e.. they can be applied across a range of sectors: manufacturing or services; public or private. Thus, Dunleavy and Hood (1994: 9) talk of NPM as moving 'down group' or 'making the public sector less distinctive as a unit from the private sector'; and Hood (1991: 5) sees NPM as requiring the need to use 'proven' private sector management techniques in the public sector (see also Cutler and Waine, 1997: 5).

NPM is discussed as effectively a polar opposite to 'public administration'. The operation of the latter can be approached by seeing it as an inversion of NPM. In public administration, where costs of public sector services are discussed, this is seen as referring to 'inputs'. This, means, for example, that costs will be presented in terms of expenditure on labour of various kinds (e.g. medical, nursing) or certain types of provisions (e.g. drugs); or on functions (e.g. hospital laundries). What, it is suggested, is likely to be absent is measures of the cost of outputs or what is 'produced' by such inputs.

In turn, this suggests that accountability and control are procedural. For example, presentation of expenditure in terms of what resources are spent on is consistent with parliamentary accountability. Hence, in the context of NHS organisation in the 1950s, requiring hospital management committees, Regional Hospital Boards (RHBs) and Boards of Governors (BGs) to present expenditure in this form allows for a check that expenditure is being undertaken for purposes regarded as 'appropriate' to the Service by parliament. Equally, however, such approaches could be seen as inimical of *managerial*

concepts of accountability. Thus, for example, emphasis that resources be allocated to a given range of categories and functions means that discretion over budgets must be limited. Equally cost data might be expected to be of limited use for internal management purposes because the information collected does not refer to 'outputs' or standards of performance in relation to such 'outputs' but rather it is collected for purposes of external procedural accountability.

Finally, if managerial accountability is absent or downplayed then the correlative requirement for clear lines of managerial (as against procedural) accountability are absent. Thus, for example, activities which 'drive' or generate costs (e.g. clinical activity) could be initiated by organisational actors (notably doctors) who are neither managerially responsible for such costs or managerially accountable to other actors (hospital administrators) for such costs.

As was indicated earlier, the NPM/public administration opposition involves an implicit periodisation – public administration refers to an 'earlier' period, NPM to the 'later'. In locating this 'periodisation' Hood, writing in 1991, refers to 'the role of new public management...over the past 15 years' as 'one of the most striking international trends' (Hood, 1991: 3). This situates NPM as coming into operation in the mid 1970s thus coinciding with the break down of the post-war 'long boom' and the shift from steady growth and full employment to a more unstable macro-economic environment and persistently higher unemployment (on this transition, see Glyn et al., 1990).

The emergence of NPM is linked to much less propitious conditions for public expenditure generally and for expenditure on social welfare in particular. The link is not fortuitous since NPM can be seen as a mechanism which at least promises to give 'more'

(output) for 'less' (expenditure) via the combination of the discipline of performance standards and the managerial freedoms stemming from greater discretionary control over budgets. Thus Hood (1991: 3) argues that NPM is linked to various 'megatrends' one of which is 'attempts to slow down or reverse government growth in terms of overt public spending and staffing' (ibid.).

In terms of this periodisation the NHS in the 1940s and 50s is situated in an epoch of public administration. This has one important implication. A central part of the argument of this thesis is that, through a variety of mechanisms, the level of NHS expenditure was constituted as a political problem in the period under review. As was indicated above, NPM approaches involve the claim that 'more for less' can be delivered and thus that constraints on service expenditure are consistent with constant or even rising standards of service provision.

In contrast public administration implies that an expenditure 'problem' will be met with a corresponding cutting back on the objectives of the service since there are no mechanisms, unlike under NPM, for transforming the efficiency of public sector services. A number of manifestations of such a response can be seen in the period under review and have been discussed in earlier chapters. For example, both Conservative and Labour governments considered offering a radically more restricted dental and ophthalmic provision limited to 'priority' groups. Similarly one of the expected outcomes of dental, ophthalmic and prescription charges was that they would reduce the demand for drugs and appliances. This suggests that the NHS in this period responded to perceived expenditure problems in a 'non managerial' way. It is now necessary to examine how far such an argument can be sustained. To pursue this question the next section examines the

initial form in which NHS hospital expenditure was presented and the critique of this form of presentation.

The Critique of ‘Public Administration’? The Problems of Subjective Forms of Cost Accounting

The form of presentation of hospital accounts under the NHS were, initially, governed by Statutory Regulation No. 1414 which was laid before Parliament in June 1948 and came into operation on the ‘Appointed Day’ (5th July 1948) (Statutory Regulations, 1948: 734). These regulations governed the way in which Boards of Governors of teaching hospitals would submit estimates and statements of expenditure to the Minister. They also governed the equivalent submission from Hospital Management Committees (HMCs) to RHBs and thence to the Minister (ibid.: 736-7). In both cases estimates and expenditure were broken into three broad categories: ‘administrative’, ‘hospital maintenance’ and ‘other expenditure’ (a residual category including everything not in the first two categories, ibid.: 736). The most significant (current) expenditure area, ‘hospital maintenance’, was, in turn, broken down into eight sub-categories: salaries and wages; provisions; uniforms and clothing; drugs, dressings, medical and surgical appliances and equipment; fuel, light, power, water and laundry; maintenance of buildings, plant and ground; domestic repairs, renewals and replacements; and (another residual) ‘all other expenses’ (ibid.: 736).

These regulations related to the *external* accountability of BGs, HMCs and RHBs (RHBs) rather than to cost data which would be used by hospital management whether at regional, HMC or BG level. On this issue the regulations were not specific. They merely stipulated that ‘Each Board of Governors and Hospital Management Committee shall prepare annual cost accounts in such a form as the Minister may require...’ (ibid.: 741).

In May 1950 King's Fund and the Nuffield Provincial Hospital Trust were asked to undertake costing investigations which could form the basis for the recommended mode of internal cost accounting in NHS hospitals and their reports are discussed below. However, as an interim measure, a committee of Treasurers of Regional Hospital Boards was set up to recommend an appropriate form for 'a relatively simple system of cost analysis' (Ministry of Health, 1952: 3). These were embodied in the first NHS *Hospital Costing Returns* which were published, for fiscal year 1950-51, in 1952. Table 8.1 shows, in an abbreviated, form how these accounts were presented. The Table is given to illustrate the way the RHB Treasurers considered that internal cost accounting data ought to be presented. Rather than giving a full list of cost headings, major cost items are included and selected more minor cost categories are shown to give some idea of the relative (estimated) cost of different items. The illustrative data is given for certain London teaching hospitals and the aim of the discussion is to locate this form of cost presentation in the debates on cost control in hospitals during this period.

'Subjective' Costing

One striking feature of the Table is the attention given to individual items of expenditure. In fact this feature is de-emphasised in the adapted version presented in Table 8.1. In the costing returns there is cost data for eight separate items under the broad heading of 'running charges' (five of which are shown in Table 8.1); and cost data for a further twelve items given under the general heading 'standing charges' (of which eight are shown in Table 8.1).

Table 8.1: Average Cost per Week of Maintaining a Patient of Maintaining a Patient, Selected London Teaching Hospitals, NHS Costing Returns 1950-51.

	Barts	London*	Royal Free*	Guy's	Middlesex
1. Available staffed beds	542	826	854	635	712
2. Occupancy Rate	91	92	87	88	92
3. Out-patient attendances	338,909	585,715	508,351	386,524	359,748
4. Provisions	£ 3.47	£ 2.19	£ 3.26	£ 3.65	£ 2.85
5. Patient's clothing	£ 0.05	£ 0.05	£ 0.02	£ 0.03	£ 0.01
6. Drugs, Dressings	£ 3.33	£ 2.96	£ 2.88	£ 3.47	£ 2.94
7. Bedding	£ 0.20	£ 0.25	£ 0.27	£ 0.21	£ 0.21
8. Cleaning	£ 0.20	£ 0.20	£ 0.21	£ 0.31	£ 0.22
9. Total Running Costs	£ 7.55	£ 5.93	£ 7.00	£ 7.56	£ 7.00
10. Medical Salary	£10.04	£ 5.80	£ 5.57	£ 9.72	£ 6.68
11. Nursing Salary	£ 6.62	£ 4.35	£ 5.56	£ 5.79	£ 5.10
12. Other staff wages	£11.18	£10.92	£10.02	£ 9.93	£10.22
13. staff uniforms	£ 0.55	£ 0.18	£ 0.26	£ 0.26	£ 0.35
14. Fuel, light, power, water	£ 1.52	£ 1.35	£ 1.60	£ 1.22	£ 1.27
15. Maintenance	£ 1.45	£ 0.64	£ 0.51	£ 1.58	£ 0.38
16. Total Standing Charges	£34.37	£24.68	£25.04	£29.15	£25.86
17. Direct Credits	£ 3.13	£ 2.09	£ 2.07	£ 1.92	£ 2.63
18. Net standing charges	£31.24	£22.59	£22.97	£27.23	£23.23
19. Extraordinary expenditure	-	£ 0.97	£ 0.71	£ 0.66	£ 0.72
20. Total inclusive net cost	£38.80	£29.50	£30.69	£36.63	£31.52
21. adjusted for out-patient attendances	£28.20	£20.71	£22.35	£26.47	£24.27
22. adjusted for occupancy	£26.19	£19.31	£20.25	£23.70	£22.71

Source: adapted from Ministry of Health (1952).

This was characterised as a ‘subjective’ approach to the presentation of cost data. The term does not connote that the data was unreliable because it reflected a ‘subjective’ or personal judgement but rather that costs were expressed under given particular ‘subject’ headings e.g. provisions, nursing salary, maintenance etc. There is also a parallel between this feature and the form of presentation for annual hospital accounts in the 1948 regulations. Both grouped costs under ‘subjective’ headings and there are a number of instances where the headings are identical e.g medical salaries, nursing salaries. Indeed this parallel was recognised by the Treasurers of RHBs who saw their scheme as an ‘extension’ of the expenditure categories contained in the 1948 Regulations (Report of the Costing Sub-Committee Appointed by the Committee of Regional Boards, MH 137/13).

This aspect of the costing returns would seem to correspond to a ‘public administration’ approach. As was indicated above, concepts of NPM characterised it as focusing on costs of ‘outputs’ whereas public administration approaches cost ‘inputs’. The ‘subjective’ focus in the costing returns seems to reflect such a standpoint because it indicates the allocation of expenditure (under ‘subject’ headings) but there is no apparent link to what is produced using such inputs. In this respect cost accounting for internal hospital management purposes in the NHS Costing Returns could be seen as similarly aping a procedurally based set of practices designed for upward and external accountability to the Ministry and Parliament. In this respect the Costing Returns could be argued to be characteristic of the ‘era’ of public administration.

However, there is also a case that this over-simplifies the picture. The above account suggests an indifference to the use of cost data by hospital management as a means to

improve hospital performance. Yet there are a number of aspects of both the Costing Returns and the critique of 'subjective' accounting practices which suggest a much more developed concern with using accounting data in internal hospital management. These two aspects will be examined in turn.

The Costing Returns: a (cautious) Managerial Reform?

The argument outline above has suggested that the presentation of hospital cost data as embodied in the Hospital Costing Returns could be seen as exhibiting an indifference to the use of cost data for internal management purposes. However there are aspects of the returns which suggest that the potential use of such data for management control *was* seen as significant.

A characteristic feature of NPM approaches has been the attempt to draw conclusions on performance standards by comparing units providing what, at least are seen to be, similar services. For example, following the introduction of the Patient's Charter, comparative information on NHS Trust 'performance', against Citizen's Charter targets such as waiting times, has been published (for an example, see Cutler and Waine, 1997: 186-7). Comparative studies of 'performance' have been seen as potentially indicative of organisational 'best practice'.

Such a concern with comparative performance can be seen in the Costing Returns and are manifested in a number of respects. Data presented is explicitly comparative since it shows costs in either individual hospitals or groups of hospitals under HMCs or (as in Table 8.1) BGs. Equally the returns sought to present data on hospitals classified by type. Thus hospitals were grouped into fourteen distinct categories (Ministry of Health, 1952) which were designed to allow for comparison of units of a similar character.

There is also what might be seen as an ‘overall’ cost performance indicator since data is presented on the ‘average cost of maintaining a patient per week’. These figures were presented in ‘net’ terms by deducting ‘direct credits’ such as payments for accommodation by staff (see column 17). There were also attempts to refine this indicator by presenting it in three variant forms. Thus column 20 gives a ‘total’ inclusive net cost figure. However, this encompasses costs incurred for in-patient and out-patient activity. The Report of the Treasurers of RHBs had pointed out that ‘...the differing incidence of out-patient expenditure distorts comparative hospital costs to such a degree that some provision should be made for this factor...’ (Report of the Costing Sub-Committee Appointed by the Committee of Regional Boards, PRO, MH 137/13).

The potential significance of variations in the extent of out-patient work can be seen in Table 8.1 which shows, for example, that out-patient attendances at the London were over 70 per cent higher than at Barts. In the Costing Returns adjustment for this work was made by using a convention adopted by the wartime Emergency Hospital Service (EHS) that ‘...five out-patient attendances represent the costing equivalent of one patient day’ (Ministry of Health, 1952: 3) and the effect of this adjustment can be seen in column 21 of Table 8.1. The Costing Return recognised that this assumption was ‘questionable’ and that ‘true out-patient costs can only be ascertained by departmental costing’ (ibid.). However, it argued that ‘in the absence of any other accepted standard it has been adopted for the sake of uniformity’ (ibid.).

The third variant of the ‘inclusive net cost’ figure involved an adjustment for the occupancy rate (Table 8.1, column 22). This reflects the fact that certain costs (e.g. maintenance of the fabric of a hospital building) will not vary with occupancy levels and

hence will be contributory to a higher unit cost. In addition the broad classification of costs was designed to distinguish costs 'which tend to vary directly with the number of patients' (ibid.) classified as 'running costs' (c/f columns 4-9, Table 8.1), and those 'which tend to remain unaltered by normal variations in occupancy' (ibid.) classed as 'standing charges' (columns 10-16, Table 8.1). In addition figures are given for 'extraordinary expenditure' (column 19, Table 8.1) 'which is not repeated yearly or more frequent intervals' (ibid.) thus there was an attempt to distinguish this item from regular expenditure.

The Costing Returns were seen as working within 'the limitations of the present costing system' (ibid.: 4). However they *were* regarded as serving an internal management function. Thus it was claimed that '...comparisons between the average costs of comparable hospitals and investigation into the reasons therefor should...lead to improvements in methods of administration and to economies' (ibid.). Equally the managerial rationale could be seen as reflected in the form of cost presentation. The grouping of hospitals by type could be viewed as facilitating reasonable comparisons as would the adjustment for variations in out-patient attendances. The further adjustment for occupancy levels could be seen as a means of distinguishing factors within and outside internal management control. For example, by their nature many isolation hospitals would be likely to operate with low occupancy rates which would increase (unadjusted costs per patient week).

Of course, this is not to say that such comparative data was not problematic. For example, hospitals classed as 'mainly general' were defined as 'more than 50 per cent general' (i.e. falling under the categories of medical, surgical, gynaecological and

obstetric cases) (ibid.: 5). Such hospitals also would have ‘a specific allocation of beds for the chronic sick’ (ibid.). This meant that hospitals with a considerable variation in the percentage of beds for the chronic sick would be classed under the same hospital type and this would have implications for costs. Equally ‘wholly general’ hospitals could contain a considerable variation of ‘medical’ and ‘surgical’ cases and there was no data allowing for any differentiation of medical and surgical specialties let alone differentiation of case-mix within specialties.

Furthermore, even in its own terms there were inconsistencies. As was indicated above the general approach in adjusting cost data for in-patient attendances was to use the EHS ratio for out-patient attendances to costs per in-patient day (Ministry of Health, 1952: 3). However, the Costing Returns also state that ‘where...the actual cost of out-patient departments is known that figure is used’ (ibid.). It is not clear what ‘actual cost’ meant in this context given that it would be highly unlikely to reflect any uniform costing approach and in addition this practice generated differences in some in-patient adjustments which reflected the EHS conventions and others which did not.

Nevertheless the Costing Returns *were* designed with a managerial objective in view and this is reflected in explicit statements of purpose such as ‘to lead to improvements in methods of administration’ (ibid.: 4) but also (see above) in specific design features. Thus they can be seen as a cautious instalment of a managerial reform project. ‘Subjective’ expenditure headings were a familiar feature of hospital accounting systems being reflected in sources like the Hospitals Yearbook (see for example, British Hospitals Association, 1940); and in larger local authority such as the London County Council. They were, of course, also the prescribed form for external cost data in the regulations

adopted in 1948. Thus the RHB Treasurers Report and the Hospital Costing Returns can be seen as seeking to adapt familiar forms of presentation of cost data to purposes of managerial control. However, if this was a cautious version of a managerial reform project there was also a more radical variant which sought to jettison the 'subjective' approach altogether.

Clearing the Ground for Management Accounting: the Critique of 'Subjective' Cost Data

This radical reform project can be traced in a number of sources: it was frequently reflected in the professional accounting journals and reference will, in particular, be made to contributions in *The Accountant*; the basis of this critique can also be seen in pre-war writings particularly in the standard text of Captain J.E. Stone *Hospital Management and Administration* (1939); and it was also central to the two semi-official reports referred to in the first section.

As was indicated in the last section, the Costing Returns embodied an overall cost indicator, that of maintaining an in-patient for one week. For the critics of the 'subjective' method, however, this overall indicator was problematic. Central to this critique was the conception that hospitals were complex institutions involving a plurality of activities. What followed was that cost data and cost units ought to be differentiated according to the nature of the activity involved. Thus, for example, the 'product' of a hospital boiler house was steam; of a cleaning function, a volume of space cleaned; of a radiology department varieties of diagnostic X-rays. For the critics it made no sense to divide costs generated by these diverse activities into a single unit, the 'in-patient week'. Thus Stone (1939: 764) argues with respect to measures of hospital unit costs that '...there is no

single unit that is suitable for the whole, but...if expenditure is divided into proper sections, there are divisions which are perfectly suitable each for its own section'

The corollary of the use of the *single* divisor (e.g. the in-patient week) meant that the *individual* 'subjective' headings (provisions, heating, radiology, medical salaries etc.) were not connected to any *specific* activity measures. *The Accountant* complained that with 'subjective' cost accounting 'one looks in vain...for any information as to the costs of running a medical ward and a children's ward' (Unsigned, 1946: 78). In a similar vein the NPHT report argues that the Hospital Costing Returns involved the problem that 'there is nothing to show what service the hospital is giving' (NPHT, 1952: 24).

The abstraction of the 'single divisor' could be seen as being reflected in the Costing Returns themselves. Thus if 'standing charges' were seen as remaining 'unaltered by normal variations in occupancy' then what logic could there be in linking them to a patient based 'unit'? In turn this frustrated the use of the data for comparative purposes. The single unit measure ran into the problem of the diversity of hospital contexts and activities. This could be dealt with by comparing *specific* activities e.g. radiology departments against other radiology departments. *The Accountant* claimed that '...all that is wanted is a uniform system of cost accounting which will show the cost of the various activities carried out in hospitals so that the cost of an activity in one hospital may be compared with the cost of a similar activity in another hospital of equal size and type' (Unsigned, 1950: 258; see also Stone 1946: 133; Unsigned 1946: 78 and NPHT, 1952: 24-5).

The logic of this critique was the outright rejection of the 'subjective' approach. Thus such cost data were seen as inconsistent with organisational divisions within hospitals.

For example, whereas doctors and nurses worked in specific wards, or at least could have their working time allocated to such wards the cost of their working time, under 'subjective' headings was grouped under, respectively, medical and nursing salaries. *The Accountant* advocated jettisoning subjective cost data in favour of '...the objective system, a system conforming to the organisation of the hospital whereby accounts are maintained for each and every unit of the organisation...' (unsigned, 1946: 78). This, echoes Stone's argument in the 1939 edition of his standard text, that 'hospital costs must be departmentalized' (Stone, 1939: 765); and was reflected in arguments for departmental costing in both the NPHT and King's Fund reports discussed below.

Thus this body of literature can be seen to constitute the radical managerial reform project. To illuminate the nature of this project and its underlying organisational implications examples of how it was designed to function in a hospital setting will be analysed in the next section.

The Radical Reform Project: Management Accounting as 'Best Practice'

To understand the nature and implications of this radical managerial reform project with respect to hospital cost accounting it is necessary to return to another theme discussed in the first section. A characteristic of the NPM/public administration opposition is the different conceptions of the relationship between public and private organisational structures and practices. Thus under public administration public and private sectors are seen as spheres in which distinct organisational principles and techniques ought to operate. In contrast NPM is seen as characterised by an imperative to import private sector techniques which are frequently seen as a condition of improving the performance of public sector organisations (Dunleavy and Hood, 1994: 9; Hood, 1991: 5).

The radical managerial reform project in hospital cost accounting can be seen as recommending such an importation from the private sector via the use of the precepts and techniques of management accounting. One way of approaching this borrowing is to set it in the context of another managerial reform project *within* the UK private sector. This has been broadly characterised by Tiratsoo and Tomlinson (1998: 35) as ‘the American productivity gospel’ which involved, in the 1950s and early 60s ‘...determined and unparalleled efforts to convince British business that it should modernise on American lines’ (ibid.). These efforts were manifested in a number of forms but one notable example was the work of the Anglo-American Productivity Council (AAPC). This body was established in 1948 and worked via teams including membership from the principal British employer’s associations, the British Employers Confederation and the Federation of British Industry; the Trades Union Congress; and representatives of American employers and union (Tomlinson and Tiratsoo, 1993: 134). The work of the AAPC was diverse covering studies of particular industrial sectors but also management techniques. Such diversity of output make its work difficult to summarise but Tomlinson and Tiratsoo (1993: 139) point to an analysis of 58 AAPC reports which saw ‘modern methods of costing’ as one of the five factors deemed to account for higher US productivity.

The nature of such ‘modern methods’ can be approached by looking at the AAPC Report which examined management accounting. One of the features highlighted in the Report was the status accorded to accountants in the internal organisational structure of American firms. It was observed that that senior accountants in the US firms were referred to as ‘controllers’. This was seen as indicative of the perceived role of

management accounting in the US: 'the very title "controller" instead of chief accountant is significant. It puts the emphasis on the control aspect accounting rather than recording' (AAPC, 1950: 19). The Report quoted the following definition of this role used by the US 'Controller's Institute'. This stated that it was 'to measure performance against approved operating plans and standards and to report and interpret the results to all levels of management' (ibid.). Thus the function of 'management accounting' accounting practices were to 'guide...the management...in deciding from actual results what has to be done to make the plan work' (ibid.: 18).

A central distinction with respect to performance measurement has been made by Carter, Klein and Day. They distinguish indicators which are claimed to act as 'dials' from those which are seen as 'tin openers'. 'Dials' are said to provide 'a precise measure of inputs, outputs and outcomes based on a clear understanding of what good and bad performance entails' (Carter et al., 1992: 49). In contrast 'tin openers' operate by prompting 'interrogation and inquiry' (ibid.) and thus operate in a context in which such a 'clear understanding' of performance standards does not apply. A return to this distinction will be made later but it is clear, at least at certain points in the AAPC account, that management accounting is seen as producing 'dials'. Thus the Report argued 'once a target has been set which is measurable in figures either dollars of expense, hours of work, or units of output the officers *expect their managers and foremen to reach that result*' (AAPC, 1950: 22, my emphasis).

In turn this was seen as having clear implications for forms of organisation. Thus targets had to be aligned with organisational roles. It was argued that a consequence of the emphasis on performance standards was '...the necessity of determining for which items

of expense and for which results each manager is responsible' (ibid.). Hence one variant of management accounting 'standard product costing' was seen as operating via a clear set of organisational relationships. Industrial engineering techniques were seen as setting appropriate technical standards in terms of requirements of materials and labour. In turn these were translated into cost terms via 'appropriate prices' for materials and labour and allocation of overhead expense (ibid.: 41) and cost targets were set.

Neither the King's Fund nor the NPHT reports make direct reference to specific private sector models. However, both argued for the relevance of private sector techniques which are seen as transferable to the public sector and both contains formulations which echo key precepts of the AAPC Report. On the relevance of private sector experience the King's Fund Report argued that private business uses accounting methods as 'instruments of control' and that 'we consider it equally desirable to set up a similar system to control the expenditure of public funds' (King Edward's Hospital Fund, 1952: para. 105). The NPHT report is somewhat more tentative since part of its object was 'to find out to what extent standard costing as used in industry could be applied in hospitals' (NPHT, 1952: 49). However, such a transfer was seen as potentially viable and standard costing was said to have '...been found of great value to management as a method of control' (ibid.).

Equally, both documents saw clear lines of managerial accountability as a corollary of the application of management accounting in hospitals. Thus the King's Fund Report argued that appropriate use of cost accounting 'pre-supposed a properly aligned organisation so that responsibility may be definitely fixed' (King Edward's Fund, 1952: para. 52). While the NPHT Report stated that the recommended departmental costing system (discussed in more detail below) '...has been devised with the purpose of

providing departmental heads and hospital management committees with the information necessary for internal financial control of the hospital' (NPHT, 1952: 26).

However, if these were the key underlying precepts of the radical managerial reform project it remains to explore how it was to operate as a functioning system. There were important differences in detail between the two reports. In the case of the NPHT a 'prime' or 'direct' cost approach was used (see Appendix 1). What this meant was that the costs of each department were traced (as far as was possible) in terms of 'direct' costs. This can be illustrated by taking the example of medical in-patient department costs (NPHT, 1952: 110). Direct costs for this department consisted of salaries and wages of medical staff; of nursing staff and materials (ibid.: 110-111). Within 'materials' provisions were excluded because they were charged to another 'department', catering (see ibid.: 123). Equally, although the ideal was direct use of labour by the department, some estimation was required to allocate the labour time and hence cost of housemen or student nurses.

In contrast, the King's Fund Report initially broke departments into three categories: patient departments, specialist service and general services (King Edward's Fund, 1952: para. 38). In terms of broad classifications the NPHT divided departments into two categories, 'medical' which subsumed the King's Fund 'specialist services' such as laboratories (NPHT, 1952: 114) and 'non-medical services' which broadly corresponded to the King's Fund 'general services' such as the boiler house (ibid.: 119). However, the central difference between the two documents was that the King's Fund Report advocated charging general service expenditure to the patient and specialist departments. Thus the aim was to provide a *total* cost for these departments. The reason for the difference in

approach related to views taken on allocation of such general service expenditure in the two reports. In some cases such costs could be directly traced. For example, where laundry was supplied to a particular ward then it would be possible to charge this to the ward. However, in other instances such direct charging was not an option. Thus, for example, maintenance work on the external fabric of a building or on the entrance had to be allocated via a formula. In the King's Fund case, for example, this was based on the share of hospital space taken up by the department (King Edward's Fund, 1952: para. 156). The NPHT Report was uneasy about the use of such formulae for allocation of overhead. The Report argued that attempts to show total costs for medical and specialist service departments 'had...to be based on a succession of arbitrary allocations' (NPHT, 1952: 29); and that reliance on 'direct costs' was 'sufficient to provide all that is needed for the financial administration of hospital management committees and boards of governors' (ibid.). Thus while both reports favoured a departmental costing system the King's Fund sought to allocate general service expenditure to medical and specialist departments; whereas in the NPHT approach there was no attempt to allocate general service expenditure to medical or specialist departments.

The principal object of this Chapter is to analyse the extent to which pressures on NHS expenditure elicited a 'managerialist' response in the period under review and it is not necessary to further discuss these differences in method. However, it is essential to show why 'departmental costing' (the favoured approach in both reports) was seen as working as an aid to internal hospital management. To do this material from the NPHT Report will be analysed. This Report was substantially longer than that of the King's Fund and thus allowed for somewhat more detail in the presentation of the illustrative material.

Tables 8.2 and 8.3 shows two of the NPHT 'samples of departmental cost statements' for a medical ward and a laundry. An examination of both can serve to illustrate what was seen as the advantage of departmental costing. In both cases costs are presented alongside measures of activity; in-patient days for the medical ward; and pieces washed for the laundry. In this sense there is a distinction with 'subjective' cost accounting in that activities are connected to costs. Equally expenditure is connected to a given organisational function, the medical wards and the laundry. Total costs are divided by 'units' to give the unit cost figure. Thus, for example, in the case of the medical ward total expenditure over the period covered (£9,423) is divided by the 'unit of cost' 11,974 (actual) in-patient days to yield a cost per in-patient day of 80 pence. The 'problem' of the single divisor is avoided because 'units of cost' are differentiated according to what is seen as appropriate to the department; in-patient days in the case of the medical ward; cost per '100 pieces' in the case of the laundry. Thus the unit cost information could be regarded as adapted to the needs of 'departmental management'. Further the combination of cost and activity data could be viewed as providing a 'pointer' to management. For example, in the case of the medical ward changes in unit costs could be linked to occupancy rates and average length of stay.

Thus departmental costs, while not given in a definitive form, the NPHT study was subtitled 'an experiment in hospital costing', were seen as the key technique in a radical managerial reform project designed to use management accounting as a tool of internal hospital management.

Table 8.2: Sample of Departmental Cost Statement: Medical Wards.

Period: 1.10.51 to 31.12.51: Group A: Hospital A

Unit of Cost: In-Patient Days

Beds Available: 143 Percentage Occupancy: 89.64

Available In-Patient Days: 13,156 Actual In-patient days: 11,794

Patients admitted: 541 Average length of stay: 21.80

Expenditure Heading	Cost	Unit Cost
Consultant Salary	£1078.13	£0.09
Registrar/Senior House Officer Salary	£ 578.77	£0.05
Housemen Salary	£ 380.16	£0.03
Nursing salary	£5910.76	£0.50
Ward maid salary	£ 499.99	£0.04
Dressings	£ 360.12	£0.03
Instruments/medical appliances	£ 171.85	£0.01
Hardware/crockery	£ 105.38	£0.01
Printing/stationery	£ 105.02	£0.01
Furniture	£ 180.75	£0.02
Cleaning, bedding, maintenance materials	£ 52.06	
Total	£9,423.00	£0.80

Source: NPHT (1952)

Table 8.3: Sample of Departmental Cost Statement: Laundry.

Period: 1.10.51 to 31.12.51: Group D: Hospital F

Unit of Cost: 100 pieces

Pieces washed: 78,257

weekly pieces washed: own laundry 5417; other hospital 603

pieces washed: white coats 1625; aprons 9156; dresses 1575; overalls 156; Theatre gowns 3696; blankets 281; counterpanes 740; pillow slips 6970; sheets 8266; draw sheets 5412; hand towels 2841; bath towels 1408; roller towels 564; other 35, 567

Expenditure Heading	Cost	Unit Cost
Superintendent salary	£ 76.13	£0.10
Other Salary	£381.39	£0.49
Hardware, crockery, cleaning, furniture, furnishings	£ 73. 46	£0.10
Work done by other hospitals	£81. 62	£0.10
Total	£612.60	£0.79

Source: NPHT (1952)

Central to this reform project was the shift from subjective to departmental accounting systems. Notwithstanding the differences between the NPHT and King's Fund reports the two bodies issues a joint statement in December 1952 which stressed their 'complete agreement' on this and included the recommendation that 'the existing accounting system based on subjective analysis of expenditure...be discontinued...[and] that an accounting system based on the departments and services of the hospital be substituted'(King Edward's Hospital Fund/NPHT, 1952: 678). Furthermore this belief in the inadequacy of 'subjective analysis' was espoused by the Guillebaud Committee in its Report where it argued that 'departmental costing will more than repay the cost of its introduction in promoting increased efficiency and a fuller sense of responsibility for spending among all those concerned with the running of hospitals' (Cmd. 9663: para. 354).

The agreed recommendation of two influential bodies which had been asked to investigate the issue by the Ministry and the endorsement of the Guillebaud Committee appeared to be a powerful platform for the managerial reform project. However, the concept of sweeping away the subjective presentation did not materialise. Thus, in an article published thirty years after the Guillebaud Report, Bourne and Ezzamel (1986) raised criticisms which are similar to those used by critics of subjective accounting in the 1950s. Costing information at the level of the hospital was said to be 'subsidiary to the main form of recurrent grant accounting' (ibid.: 53). In turn such accounts were given in terms of a 'subjective analysis' which 'analyses expenditure according to its 'subjects' i.e. different categories of materials or labour' (ibid.). One of the 'main' outputs of 'costing in the hospital side of the NHS' was said to be 'figures of total average cost per patient-day (ibid.) in other words a variant of the 'single divisor' discussed above. NHS

cost data was criticised for reporting costs 'at a very high level of aggregation' (ibid.: 56); and producing cost data which was 'virtually useless' for comparative purposes (ibid.). In short three decades after the reform project academic accountants were making criticisms of NHS accounting practices which were virtually identical to those embodied in documents like the NPHT and King's Fund reports. This leads to the question as to why the reform project did not achieve its objectives and, in the last section, an attempt will be made to discuss some of the major problems posed by the plan to introduce 'departmental costing'.

The Managerial Revolution Postponed: the Problems of Departmental Costing

The problems of the managerial reform project can be traced by looking back to some of its presuppositions as outlined in the two key reports and embodied in the AAPC study of management accounting. In addition the argument makes use of data collected by Montacute in a study of RHBs, BGs and HMCs. He sent out 214 questionnaires and obtained 144 responses and his research which was published in 1962 gives interesting insights into reactions to the change in accounting practices following the 1955 Working Party Report.

With respect to the problems of implementing the reform programme two features stand out: the assumption of clear links between organisational responsibility and financial accountability; and the assumption that it was possible to define a product or process to be costed and, at least in some versions, that a 'standard' or expected cost could be defined.

With respect to the first of these assumptions, hospital organisation posed a particular problem. Central to the generation of costs in hospitals was clinical activity and such

decisions were taken by doctors. Thus not only were the salaries of doctors a key cost element but medical decisions had implications for nursing staffing levels, the demands on service departments such as radiology, laboratories and physiotherapy. The logic of the reform project was to link such decisions with financial accountability. This could have been done by making certain clinicians budget-holders or via giving such responsibilities to non-medical budget holders to whom clinicians would be accountable. However, either model was inconsistent with the clinical autonomy. The latter was problematic because it involved subjecting clinicians to non-clinical control; but the former opened the possibility of clinical managers intervening in the practice of colleagues perhaps of equivalent or 'superior' medical status.

The problem raised by clinical autonomy was regularly reflected in the sceptical reception amongst hospital authorities to departmental costing proposals. For example, material on attitudes to the reform of cost accounting can be found in evidence given to the Guillebaud Committee. In this evidence frequent reference was made to the effects of such autonomy. Thus representatives of North West Metropolitan RHB argued 'in the case of certain unit costs – e.g. in the operating theatre – it was difficult to understand what executive action could be taken once the information had been obtained. It was well known for example that some surgeons were slower than others and would remain so even when unit costs revealed their slowness' (North West Metropolitan Regional Hospital Board, Oral Evidence to the Guillebaud Committee, GC (53), 6th Meeting, MH 137/227). Similar reservations were expressed by other RHBs thus the East Anglia Board representatives thought that the 'value' of cost accounting techniques was 'unknown in

medical departments' (East Anglia Regional Hospital Board, Oral Evidence to the Guillebaud Committee, GC (53), 6th Meeting, MH 137/227).

There was similar scepticism in the Treasury where the lack of the clear lines of accountability presupposed in reform cost accounting proposals was highlighted. It was argued, with respect to evidence of variations in hospital costs 'will doctors [in a high cost hospital] be told they must spend less time with their patients? Are we anywhere near getting round to a position in which such a thing could be said and who would say it?' (Workman to Chatterton, Hospital Costing, 4th January 1956, T 227/802).

The 'who would say it' question was a telling one and the issue was not confronted in the two reports. For example, it was, as Workman implied, unclear who was to act on the cost information provided on 'departments' such as wards or out-patient clinics.

Furthermore, while service departments such as radiology could examine how they undertook the work required of them, clinical autonomy meant that the requests for such services were outside the departmental purview. This was admitted in the NPHT report where it was stated 'it is useful to know that a pathological investigation is done in an efficient way but it would be equally useful to know whether the number of investigations is above or below the average having regard to the types of patients treated' (NPHT, 1952: 50). However, the Report was very cautious with respect to attempts to apply such a norm observing that '...it is hoped that with the co-operation of specialists in every field it might be possible to arrive at formulae which would give broad indicators of the right usage of many services which a hospital gives' (ibid.).

A similar indication of caution was the absence of examples of the use of accounting data to change practice in areas under direct clinical control. For example, in a section of

the NPHT Report giving examples of ‘the value of cost accounting in hospital administration’ (NPHT, 1952: 44-45) the positive examples of the use of cost data are drawn from the laundry, catering, stores and administration of salaries and wages (ibid.: 45). However, this virtual restriction of the use of cost data for management control to non-clinical areas had major implications for overall cost control. Thus Table 8.4 shows the NPHT estimate of expenditure by department in the teaching and non-teaching hospitals in the participant institutions. What is clear is that over half of total expenditure related to ‘medical departments’. Arguably this might overstate the percentage of total expenditure not subject to cost control in the absence of financial accountability for clinical decisions. This is because there would still be some scope for interventions in service departments such as radiology or laboratories. However, as the NPHT report admitted, this would not relate to the *demand* for the work of such specialist departments. NPHT estimates did show that in longer-stay hospitals such as tuberculosis and mental hospitals, the costs of non-medical departments made up a substantially larger share of total expenditure and hence there was potentially greater scope for cost control. However, this was double-edged since such hospitals were much less expensive to run than acute hospitals.

Table 8.4: Estimates of the share of total expenditure accounted for by different departments: teaching and non-teaching general, 1952.

Department	Teaching: General	Non-Teaching: General
Wards	19.14	21.77
Out-patients/casualty	7.52	9.66
Operating Theatres	7.52	6.99
Electrocardiology	0.15	0.07
Radiology	3.64	4.32
Laboratories	4.17	3.09
Radiotherapy	0.20	0.89
Physiotherapy	1.34	1.79
Dispensaries	5.02	6.26
Almoners	0.76	0.46
Records	3.49	2.36
Occupational Therapy	0.15	0.14
Total Medical Departments	53.10	57.80
Works and Maintenance	5.02	3.99
Boiler House	4.46	4.02
Rent and Rates	0.45	0.39
Gas, Water, Electricity	1.76	1.46
General Services	0.81	1.69
Portering Services	2.76	2.09
Cleaning Services	3.62	3.42
Own Transport	0.54	0.13
Outside Transport	0.32	0.32
Laundry	2.84	1.72
Catering, general	13.92	14.13
Residences	1.81	1.57
Nursing Training Schools	1.42	0.67
Nursing Administration	1.02	1.59
Administration	4.43	3.90
Total: non-medical departments	45.18	41.11
Trading accounts	1.72	1.09
Total	100	100

Source: adapted from NPHT (1952)

Montacute's research also found a number of examples of a concentration, in the use of accounting data for management control, on non-clinical areas. He thought this was to be expected since 'the 'hotel' side of the hospital service lent itself to costing more readily

than the 'treatment' side (Montacute, 1962: 82). This assumption was supported by evidence from his survey. One of his questions related to which departments were usually investigated following the analysis of costing data. He found that the most common areas for investigation were catering, cleaning, portering and allied services with an average of 0.9 investigations per department. In contrast in-patient and out-patients departments had, with administration, the lowest level of investigations, averaging 0.2 per department (ibid.: 100).

The 'problem' posed by clinical autonomy suggests that managerial reform could be seen as foundering on the unwillingness of a key professional group either to adopt a managerial role or cede operational control to managers. However, this view is problematic because it in turn presupposes that there was a set of operational and cost norms which could be applied in clinical and service departments but for the resistance of doctors. Thus, as was indicated above, concepts of management accounting such as those in the AAPC Report presumed standards for the use of materials and labour which were then costed to produce financial targets. However, even in the managerial reform literature there was marked scepticism with respect to such views. Thus in the King's Fund Report it is argued 'standard costs, as we understand them imply a 'blueprint' precision which is obviously impossible of attainment in the treatment of patients which indeed could only be attained on the emergence of the 'standard patient'' (King Edward's Hospital Fund, 1952: para. 118). Indeed difficulties in defining a 'medical product' can be seen in the NPHT Report where the 'unit of cost' for medical wards was 'in-patient days' not types of case or forms of treatment.

Such scepticism was also reflected in the report of the RHB Treasurers which, as was pointed out above, had recommended a modified form of subjective analysis. The authors of this Report complained that some criticisms of subjective presentation 'seem to be founded on the false assumption that hospital patients can be regarded as units of cost comparable with articles produced by a manufacturing process' (Report of the Costing Sub-Committee Appointed by the Committee of Regional Boards, PRO, MH 137/13).

There was interest in the Treasury in seeing if cost standards could be established which might form the basis for allocation of resources between Regions. A case was made for the establishment of a 'cost research group' which would investigate a 'reasonably representative region' and might 'make some inference from one region to the money required for the whole' (Owen, NHS Financial Control, 13th August 1953, PRO, T 227/802). However, it was admitted that 'hospitals are not standard units' thus it could not be anticipated that the result of such research would be the construction of a cost and resource allocation 'dial'.

The acceptance of a lack of clear cut operational and cost standards and the correlative complexity of any such research exercise was reflected in the fact that the research group working was envisaged as operating in the chosen region for between 2 and 4 years. Yet this threatened to make the research worthless for decision-making purposes. Thus a Ministry of Health official argued with respect to the 'cost research group' '...the first units visited might well have altered so much in four years as largely to vitiate the Group's original conclusion as to their financial requirements' (Marre to Mitchell, 9th October 1953, PRO, T 227/802).

This, however, created a further difficulty. Standard costs could not, on such arguments be used to determine macro allocations of funding to Regions, cost data might function as a ‘tin opener’ but not as a ‘dial’. This appeared to mean that cost accounting at the unit level would be decoupled from such macro allocations. Equally, as Montacute pointed out, in the context of control over expenditure, cost data was double edged. Thus he argued (1962: 230) that the Ministry and RHBs could not ‘call for explanations from authorities whose costs are high’ but also ‘ignore requests for additional funds from authorities whose costs are low’. Given the emphasis on constraining overall expenditure this was a potentially unpalatable effect of any attempt to link cost data with budgetary allocations.

Conclusion

The research discussed in this Chapter sought to investigate whether there was a ‘managerial’ response to the ‘problem’ of NHS expenditure in the 1950s. Such a response opened different avenues from one based on ‘economy’ precepts. The latter was negative because it either meant restricting the range of service provision (as in proposals to limit Dental and Supplementary Ophthalmic services to ‘priority’ groups); or creating obstacles to access to services (notably through charges). In contrast a managerial response can be positive because it promises better *use* of resources so that provision can be maintained or improved without increased expenditure (see Cutler and Waine, 1997: ch. 1 for discussion of this contrast).

However, as was pointed out in the first section, social scientific theories of New Public Management (NPM) appear to suggest that such a managerial response could not occur in the NHS of the 1950s. This was because it was a public institution governed by the

dictates of 'public administration'. This meant that the conditions for NPM, devolved budgets, managerial discretion and performance targets, were precluded because 'public administration' requires procedural accountability which defined out managerial freedoms and control via performance targets.

However, the documentary research and the analysis of the two key semi-official reports by the NPFH and the King's Fund suggest that such an account is over-simplified. There was both a cautious and a radical version of managerial reform in attempts to change the basis of NHS accounting practice. This venture into managerial reform was problematic and part of the problem did stem from a general support for clinical autonomy (in RHBs, the Ministry of Health and the Treasury). In this sense this reflects a characteristic of the period (see Berridge 1999:2 for a discussion of the belief in the efficacy of curative medicine in this period); and the more full blown managerialism of the 1980s and 90s has involved a much more critical view of professional practice.

However, the experience of managerial reform in the NHS of the 1950s has a broader relevance. The documentary research revealed a number of telling criticisms of the application of management accounting techniques which were raised within the Ministry of Health and the Treasury. Such criticisms are important because, in certain respects, they anticipate criticisms of NPM in the 1980s and 1990s (see Cutler and Waine, 1997 for a discussion of such criticisms). In having both a managerial reform project and its critics the NHS of the 1950s was perhaps not as far from the world of NPM as social scientific theories might lead us to believe.

Conclusion

To conclude the argument it is necessary to return to the research questions posed in Chapter 1 and to examine what lessons can be drawn, from the research, regarding the underlying mechanisms which constituted NHS expenditure as a 'problem' in the period.

The Issue of Benchmarks

The first question related to a paradox. Abel-Smith and Titmuss's (1956) work showed how modest the economic demands of the NHS were in the period to 1953-4. However Chapter 6 demonstrated that their conclusions were not accepted in the Treasury and that pressures to restrain expenditure continued up to 1960. To discuss this paradox it was necessary to research the standards used in judging NHS expenditure trends, an issue which had not previously been systematically investigated. The documentary research showed that the 'problem' of NHS expenditure involved the use of expenditure estimates made at the planning stage of the Service which served as crucial benchmarks. The 'problem' thus derived from the disjuncture between such estimates and expenditure out-turns. The research also showed that such early estimates were used right through the period: the analysis in Chapter 5 showed that they played an important role in sustaining arguments for expenditure cuts in the period of the 'crisis of expenditure'; but they also played a similar role in the late 1950s, as was shown in Chapter 6.

The paradox related to the application of different analytical frameworks. Chapter 6 points out that Abel-Smith and Titmuss's methodology focused attention not on the estimate-expenditure relationship but rather on trends in Service expenditure in real terms and as a share of national income. However the documentary research in Chapter 6, on the Treasury response to Guillebaud, showed a failure to engage with this different approach and a tendentious attempt to undermine the Guillebaud findings.

The Sources of Inaccuracy

If planning stage estimates were key expenditure benchmarks a second question related to whether they tended to systematically under-estimate likely expenditure and if so why?

The research showed that there was substantial evidence that the estimates were too low even in the context of data available when they were made. In Chapters 2 and 3 it was shown that the Ophthalmic and Pharmaceutical estimates appear to have been based on assumptions of no change from National Health Insurance take-up rates; and Chapter 4 demonstrated that anticipated hospital in-patient costs were well below those applying in the leading voluntary and municipal sector acute hospitals.

The research leads to the conclusion that there were major difficulties in coming to acceptable estimates; but also that inaccuracies were rooted in limitations in practices of estimation within the Ministry of Health. In relation to the former Chapter 3 showed that both Dental and Ophthalmic Estimates in the 1944 White Paper were probably premised on a policy of services limited to 'priority groups'. The subsequent policy shift towards universal provision meant that such assumptions were no longer applicable and they were a source of the underestimate in that document. In addition, in relation to the 1948-9 estimates, important remuneration data was available too late to be incorporated in estimates and examples were given in Chapter 5.

However, there were also limitations in the Ministry's approach to the estimates. As was pointed out in Chapters 2 and 3, it is not clear why expected Ophthalmic and Pharmaceutical demand levels appear to have been based on projecting NHI take-up rates whereas those for Dental services assumed higher take-up. In all these cases, demand backlogs could have been anticipated. Chapter 5 also showed that these differences in treatment also applied to the 1948-9 Estimates. Perhaps the most serious problems related

to the hospital estimates. Chapter 4 concluded that there was no systematic attempt to utilise cost data available on the leading voluntary and municipal acute hospitals. As a result Robb-Smith's (1944) critique of the White Paper estimates seems soundly based. Chapter 5 did point to the substantially higher hospital estimates for 1948-9 but the use of planning stage estimates as benchmarks meant that *earlier* estimating errors were politically damaging. In this respect it is also worth noting that the claim made by Campbell (1987) and Klein (1995) that officials projected from data available at the end of the inter-war period must be qualified. As was demonstrated in Chapters 2 and 3 this *was* done in the case of Ophthalmic and Pharmaceutical Services but the Dental Estimates were based on the expectation of higher take-up rates. Even more striking is the case of hospitals. There it was the *failure* to use data from the end of inter-war period which was an important element in the under-estimate. These findings demonstrate the importance of empirical investigations of how the estimates were prepared.

Intra-Service Variations

The third research issue concerned how far expenditure control problems varied between different parts of the Service. The research showed that there *were* such major differences. In Chapter 2 it was pointed out that the General Practitioner (GP) Service posed least problems of control because, whether pay was via salary or capitation, the total pay bill was pre-set. The 'pay pool' and the fact that pay was not directly linked to demand (plus the fact that accurate remuneration data was available at the time of the estimates) meant that this part of the Service was not a cause for concern even during the 'crisis of expenditure'.

In contrast Dental, Ophthalmic and Pharmaceutical Services all operated with forms of payment which linked demand and expenditure. In Chapter 5, it was shown that

substantially higher demand than had been anticipated translated into large differences between expenditure and estimates in the first two fiscal years of the Service. In the case of hospitals, even in the first two fiscal years, variances between estimates and expenditure were not large. However they were important because this was substantially the most expensive part of the Service.

Inter and Intra Party Politics and the Expenditure 'Problem'

A major aim of the thesis has been to examine how an NHS expenditure 'problem' was defined. Central to such a definition was politics. The analysis in Chapter 5 showed that there was no 'self evident' problem of NHS expenditure. The cost over-runs could be 'read' as reflecting an explosive increase in expenditure taking the Financial Memorandum, and, in effect, 1944 White Paper estimates as benchmarks. They could also be seen as a phase of adjustment to a more settled pattern in which expenditure was increasingly 'under control'.

The documentary research in Chapter 5 showed how political positions structured views on expenditure trends. These varied from seeing the NHS as part of a radical break in health politics which would experience teething troubles (Bevan); as an experiment which went too far too fast (the Labour Right); and as a departure from a golden (inter-war) age of economy (the Treasury).

The research (in Chapter 6) showed that under the Conservatives a distinctive health politics operated. Economic liberal views held by senior politicians created pressures on NHS expenditure and the NHS was a low expenditure priority. The thesis sought to break new ground by exploring the connections between the politics of Conservative social policy and the restraints on NHS expenditure. Housing was a high priority in the early 1950s because Conservative targets promised a social policy success in an area of Labour

vulnerability. The winding down of this programme in the mid 1950s opened the space for expansion of other social service programmes. The 'beneficiary' was Education. Here expenditure was deployed to prevent a policy failure. After Labour's shift to support for comprehensive schools in 1953, the structure of secondary education ceased to be a bi-partisan issue. Conservative politicians became increasingly defensive with respect to the 11+ while continuing to uphold tripartism. The dilemma was to be resolved by attempting to promote a more genuine 'parity of esteem' but this generated pressure for resources to, in particular, improve standards in secondary modern schools. In Social Security expenditure was driven by regular benefit upratings and full blooded selectivism, in many respects a 'preferred' option, was seen as politically dangerous. In the NHS consistent parsimony was related to a service seen as neither a means of exploiting a Labour weakness nor a site of Conservative vulnerability.

Responding to Parsimony

The final research question concerned responses to the effects of the regime of parsimony. As was pointed out in Chapter 1, these were necessarily diffuse but Chapter 7 examined capital expenditure; while Chapter 8 looked at the status of 'managerial' responses to expenditure constraint.

Capital investment was selected for detailed examination because it was both the area where expenditure restraint was most extreme; but also, as the research showed, where the case for substantially higher expenditure was widely accepted, even in the Treasury. As Chapter 7 showed, this case was sustained by financial yardsticks and concerns with the promotion of efficient practice in hospitals, the latter, in particular, being linked to higher patient throughput. However, an important conclusion of Chapter 7 was that the

'problem' of current expenditure continued to loom large and regularly informed Treasury reservations on a more substantial programme.

Chapter 8 analysed a different response, an alternative to economy could be to promote a managerial reform agenda. This has been a virtually unresearched area because theories of New Public Management have effectively portrayed the period as non managerial. However, the research found that, notwithstanding the characterisation of the period as one of 'public administration' rather than 'public sector management', there was clear evidence of a managerial reform project. This was manifested in attempts to reform NHS accounting practice and reflected in two important semi-official reports and the modified version of the 'subjective' approach to hospital accounting, introduced in 1957.

However, this reform project was constrained in two ways. In a period of belief in the efficacy of curative medicine (Berridge, 1999:2) even advocates of managerial reforms were chary of challenges to clinical autonomy. The corollary was that a significant range of (clinical and 'clinically driven') costs were excluded from the scope of management control. Equally doubts were expressed on whether medical practice lent itself to an accounting framework developed in the context of manufacturing. Consequently, there was a genuine 'managerial' response but it failed to achieve the impetus to displace the primary emphasis on economy.

Radical Health Policy, conservative Financial Control?

These considerations raise a final question as to whether it is possible to produce a general characterisation of the basis for the 'problem' of NHS expenditure. Arguably it can be traced to a central tension. The NHS was an example of radical health policy. It transformed the conditions of access to health care; it universalised coverage; it involved

aspirations to high standards across the Service; and it shifted the principal source of funding to general taxation.

However, approaches to financial control did not move in the same way. This can be illustrated by looking at the principal agency of such control, the Treasury. Hecla and Wildavsky (1981) sought to discuss key 'maxims' of Treasury financial control in research carried out in the 1970s.

One maxim was that 'the Treasury as an institution has never believed in the philosophy of economic growth' (ibid.: 48). This did not mean that economic growth per se was seen as undesirable but rather that expenditure trends ought not to be seen in the context of projected growth since this involved, in the words of a Deputy Secretary, committing resources on the basis of 'phoney paper growth'. Such views expressed a continuity of approach in the Treasury dating from the inter-war period (see Middleton, 1985) and formed the basis for financial control in the 1940s and 50s. As was shown in Chapter 1, Lowe (1989 and 1997a) has pointed out that ventures into longer term financial planning were a change in the method of pursuit of economy rather than a radical shift in the approach to evaluating public expenditure. The research undertaken in this thesis has also shown that this emphasis on economy was evident in Treasury approaches to health policy. Thus Chapter 6 pointed to Treasury resistance to 'social accounting'; and Chapter 7 to Treasury suspicion of the longer time horizons of the Hospital Plan.

This meant there was a tension between a radical approach to health policy and conservative concepts of financial control. This was exacerbated because of technical weaknesses in the apparatus of financial control. Chapters 2-4 pointed to limitations on Ministry of Health approaches to cost estimation. Chapter 4 showed that this could be

located in a lack of familiarity with a financial control role and a ‘distant’ relationship to health providers. This deficiency was not corrected by the Treasury because it was not, as one of Heclo and Wildavsky’s respondents told them, ‘an original research organisation’ (ibid.: 42). Consequently a further ‘maxim’ was that ‘the Treasury should not redo the work of other departments’ (ibid.). In this way unrealistic estimates entered the public domain only then to be treated as benchmarks. When a challenge to this framework was made it came from *outside* Ministry of Health and the Treasury through the work of Abel-Smith and Titmuss.

There is, finally, another dimension to this tension. As Middleton (1985: 32) has pointed out, with respect to the inter-war period, Treasury approaches to expenditure control cannot, of themselves, determine policy. Ultimately the Treasury remains subject to political control. As Chapter 6 showed, where there was sufficient political support, Treasury reservations regarding increased expenditure could be over-ruled. Consequently the conservative financial control framework can be seen as rooted in the tenacity of economic liberalism. This was clear under the Conservatives where, even if an economic liberal agenda was not pursued root and branch, it was a key influence on policy. Under Labour Bevan’s ‘gradualist’ critics were anxious that his policies were leaving the Party open to economic liberal criticism. Equally, this relates to arguments, discussed in Chapter 1, on the lack of a consensus on the welfare state and on full employment. In financial control as in other areas of health policy (see, for example, Berridge, 1999: 17-18) the NHS represented an incomplete revolution.

Appendix 1: Financial Control Concepts

The object of this Appendix is to outline the key financial concepts used in the thesis.

Gross Cost: this refers to the overall cost of a public service, in this case the NHS.

Net Cost: this is used in two senses:

- (a) to refer to Gross Cost minus revenue from charges for the public service concerned, an example in the case of the NHS would be prescription charges, Abel-Smith and Titmuss's definitions of net cost follow such a usage.
- (b) to refer to Net Cost in the sense of (a) but also deducting sources of public funding *other than general taxation*. For example the Financial Memorandum to the NHS Bill deducted expenditure financed by local authorities and from the National Insurance Fund from the expected overall expenditure to reach a 'net cost' figure. Net cost in this sense thus refers to the Exchequer cost of a public service.

Current cost: refers to expenditure relating to a single accounting period. Abel-Smith and Titmuss refined this concept to refer to expenditure which yielded current service benefits e.g. paying doctors or nurses since this 'buys' their labour in producing current health services. Some current expenditure in accounting terms does not fall into this category thus compensating a retired doctor for the prohibition of his right to sell his practice may appear as a current cost (it is met in one accounting year) but it generates no current health benefits.

Capital cost: refers to expenditure expected to yield benefits over more than one accounting period. In accounting terms stores fall into this category but most important from a health policy point of view is investment in buildings or equipment which will be expected to have a long working life.

Direct or Prime cost: used in management accounting this refers to costs which can be directly traced to a given department. An example would be the cost of laundry for patients and staff working in a particular ward. Not all internal costs can be classified in this way. Thus, some costs e.g. upkeep of the external fabric of buildings cannot be traced to the work of a given department. If they are to be included in departmental costing then they must be treated as overhead which is *allocated* to the department. If this is done then a formula will be required to allocate such overhead e.g. it could be done by taking the physical area of a given department as a proportion of the total physical area of a hospital and allocating this percentage of the overhead to the department. The difficulty with such allocation is its 'arbitrary' nature and whether such overhead costs ought to be allocated was an issue which divided the NPHT and King's Fund Reports (see Chapter 7).

Variance: the difference between expected costs and actual costs. In the thesis this is used to refer to estimates (expected costs) and out-turns (actual costs).

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